

THE CONTRACT SUPPORT COSTS WITHIN THE INDIAN HEALTH SERVICE ANNUAL BUDGET

HEARING BEFORE THE COMMITTEE ON RESOURCES HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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HEARING ON THE CONTRACT SUPPORT COSTS WITHIN THE INDIAN HEALTH SERV- ICE ANNUAL BUDGET

WEDNESDAY, FEBRUARY 24, 1999

HOUSE OF REPRESENTATIVES
COMMITTEE ON RESOURCES
Washington, D.C.

The Committee met, pursuant to call, at 11 a.m., in Room 1324, Longworth House Office Building, Honorable Don Young, Chairman of the Committee, presiding.

Members present: Representatives Gallegly, Hayworth, Kildee, Faleomavaega, Ortiz, Smith, Christensen, and Inslee.

Mr. YOUNG. The Committee for Resources will come to order. The Committee is meeting here today to hear testimony on contract support costs within the Indian Health Service, the Bureau of Indian Affairs, annual budget.

Under Rule 4 [g] of the Committee rules any oral opening statements at hearings are limited to the Chairman or the Ranking Minority Member. This will allow us to hear from our witness sooner and help members keep up their schedules. Therefore, if any members have any statements, they can include them in the hearing record under this unanimous consent.

Now I recognize Mr. Kildee, for any statement he may have.

STATEMENT OF HON. DALE E. KILDEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. KILDEE. Thank you, Mr. Chairman, and thank you for having this very, very important hearing on support costs. In 1975 we passed the Indian Self-Determination Education Assistance Act. We have not always done right by providing the dollars that are needed to administer these programs in self determination, and I think it is important that we address this as the authorizing committee. And I would like to submit my statement and also the statement of the Ranking Member, Mr. Miller, for the record.

[The prepared statement of Mr. Kildee follows:]

STATEMENT OF HON. DALE E. KILDEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, today's hearing marks a fine moment in the 106th Congress that allows us to take this opportunity to highlight the successes of native Americans and Alaska natives across the nation since the enactment of the Indian Self-Determination and Education Assistance Act of 1975.

This hearing will also provide us an opportunity to learn of the impediments that have emerged from the implementation of the Federal policy promoting Indian self-

determination, and to see what we can do to remove those impediments for the ultimate benefit of the tribes and the people they serve.

Using the tools of self-determination contracting and self-governance compacting, tribes today in financial terms operate \$840 million in Indian Health Service Programs, more than 40 percent of the agency's entire budget. The results, as I am sure the Committee will hear today, have been staggering in terms of improved local autonomy and flexibility, streamlined services, expanded programs, better accessing of alternate resources, and improved education, employment, health status and welfare of the Indian communities served.

None of this would have been possible without a true partnership between Congress and the tribes. That partnership is reflected not only in the many improvements we have made to the Self-Determination Act and self-governance laws over the years, but in the financial commitment we have shown, too, in the form of contract support costs, without contract support costs, we would be penalizing tribes, first by turning over underfunded programs to tribal administration, and then telling tribes they must further reduce those programs in order to cover the administrative costs of operating them.

Mr. Chairman, Congress's commitment to pay contract support costs in the Indian Self-Determination Act is not only morally and legally correct, but it is necessary to fulfill the policy of self-determination. The Self-Determination Program is in crisis. Though some may say tribes are victims of their own courage and success, tribes are at this moment operating hundreds of millions of dollars in programs with inadequate contract support costs. We know the problem is not the contract support cost system, because the system has been exhaustively studied and scrutinized time, and time again. The problem is one of funding. While I support the President's FY 2000 budget proposal calling for a \$35 million increase in funding for contract support costs in the Indian Health Service, I will request additional funding for contract support costs and funding for the Indian Self-Determination Fund.

We, Members of Congress, made a commitment nearly a quarter century ago to support tribal self-sufficiency. Tribes have done their part in taking over responsibility for essential Federal programs serving their people. Now we must do our part to support them. Mr. Chairman, we must restore confidence in the self-determination system.

I look forward to hearing today's testimony, and to working with the Committee and the House Interior Subcommittee to close the contract support gap that is threatening the future of the nation's Indian Self-Determination Policy.

[The prepared statement of Mr. Miller follows:]

STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE
STATE OF CALIFORNIA

Mr. Chairman. We were both here in 1975 and helped pass Public Law 93-638, the Indian Self-Determination and Education Assistance Act allowing tribes to enter into contracts with the Bureau of Indian Affairs to run Federal programs previously provided by the BIA. The concept was simple—through government to government negotiations, Indian Tribes could take over specific programs and supply services directly to tribal members thereby replacing the total Federal involvement. Our belief was that as more and more tribes gained the expertise to administer Federal programs, tribal governments would assume greater control over Federal services authorized for Indian Tribes. We were correct, the desire and ability to enter into what became known as "638 contracts" grew and evolved to include Indian Health Service programs and further to include the ability to negotiate one "self governance contract" to administer most programs within the BIA or IHS.

The problem, however has been inadequate funding of contract support costs which are necessary costs borne by an Indian Tribe to cover expenses which, when the program is provided by the Federal Government, are funded through other means. These costs can include personnel support, accounting, legal assistance and utilities. Congress and the courts agree that these funds are required, however inadequate funding has brought us to an almost crisis situation.

Several factors have contributed to this problem including quick expansion of the number of 638 and self governance contracts negotiated, wide variations in the calculations of contract support costs, and appropriation levels too low to address the need. We must get a handle on how to fund these costs as failure to do so will greatly affect direct programs to American Indians.

I don't think there are many in this room who would doubt the appropriateness and success of Indian Tribes running Federal programs, but the very success of this program could result in fewer contracts or severe caps placed on funding in the fu-

ture. Legislation which I introduced last Congress to make permanent the self governance program within the IHS, was blocked in the Senate because of the issue of contract support costs. I think that was a mistake and I will reintroduce the legislation again. However, the Appropriators have made it clear over the last couple of years that if a solution isn't found soon, they will step in and attempt to curtail spending as they see fit.

This morning we will hear from the Administration and Indian Tribes which are running successful health service programs. In addition the National Congress of American Indians will testify as to the working group they have assembled to come up with recommendations to address the problem. I look forward to all the testimony. We should not go back to the days where every American Indian had to come to the Federal Government to receive a service. I believe answers to this quandary should come from Indian country and not imposed upon tribes and I will work with all interested parties to come up with and implement viable solutions.

STATEMENT OF HON. DON YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Mr. YOUNG. I thank the gentleman. I also have an opening statement—I would just especially like to welcome my Alaskans that are here today—and I'll submit it for the record also. We have Mr. J.D. Hayworth who has joined us today also. And so we'll continue with the witness list.

[The prepared statement of Mr. Young. follows:]

STATEMENT OF HON. DON YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

I would like to welcome everyone, especially my Alaskans, to this important hearing on contract support costs.

Last year, the House and Senate Appropriations committees' were very concerned with the proposed \$168 million dollars appropriated by the Administration for contract support costs for the Indian Health Service (IHS) for fiscal year 1999. The proposed figure would have covered approximately 58 percent of contract support costs (across the board). This was unacceptable to me, the Committee on Resources and the House and Senate Interior Appropriations Committees. The Administration and Congress must remember that tribes are operating Federal programs and are carrying out Federal responsibilities when they operate self-determination contracts.

I am pleased to see that the IHS has opted to retain the \$35 million dollars that Chairman Regula added to contract support costs for FY 1999 in their FY 2000 budget. This increase coupled with the one year moratorium set on new contracts, will bring the percentage of coverage on contract support costs to 70 percent across the board.

The Committee will also hear from the Bureau of Indian Affairs with regard to their system for contract support costs. The BIA pro-rates their indirect costs, however, funding for contract support costs does not include direct costs to tribes. Tribes believe that the direct costs paid by the IHS are in fact legitimate and should also be paid by the BIA as well. It is also my belief that the BIA and IHS should remain consistent and utilize similar, if not, identical systems to pay contract support costs.

I want to remind everyone that under the Balanced Budget Act of 1977, we have strict caps on discretionary spending. In FY 2000, these caps will be lower than in FY 1999. Unless these caps are raised, that means that the Appropriations committee will have to cut back on programs rather than increasing or even level-funding them.

Senator Stevens in the Senate has told me that while he strongly supports Indian Self-Determination, he and many of his colleagues have always believed that as more and more Native organizations began to run their own programs, that Congress would see concurrent downsizing in both the IHS and BIA. To some extent, we have seen that in BIA, but we have not seen that downsizing in IHS. So, this brings us to the hearing today.

I will now recognize my Ranking Minority Member for his opening remarks.

Mr. YOUNG. The first panel is Mr. Michel E. Lincoln, deputy director of the Indian Health Service, Rockville, Maryland. Mr. Kevin Gover, assistant secretary of Indian Affairs, U.S. Department of Interior, Washington DC.

Mr. Lincoln, you are up first.

**STATEMENT OF MICHEL E. LINCOLN, DEPUTY DIRECTOR,
INDIAN HEALTH SERVICE, ROCKVILLE, MARYLAND**

Mr. LINCOLN. Thank you, Mr. Chairman. We appreciate the opportunity to be in front of the Committee today to talk about contract support costs. As a part of the President's Fiscal Year 2000 budget, we're very pleased to report to the Committee that the President has requested an additional increase for contract support costs of \$35 million.

On January 26th, the Committee, and through its chairman, has written Dr. Trujillo relative to a number of issues the Committee would like to entertain today and would like us to be responsive to. I would like to just briefly make comment on those issues and to let the Chairman know that we are prepared, though, to talk in detail about the various issues that are of concern to the Committee.

The first issue dealt with contract support cost data. And I'd like the Committee to know that we've been working with the National Congress of American Indians. We've been working with what we call our Contract Support Cost Work Group in order to assist the agency and in order to share the information that has been developed, and in a very real way validate the data that has been developed relative to contract support costs. We believe we have the best data we've ever had and we'd be willing to share that with the Committee and submit that for the record.

Mr. Chairman, the second issue that was raised discussed the Congressional intent that as more contracting was occurring that there would be, if not a one to one, there would be a similar reduction occur within the administration of the Indian Health Service. I'm here to let you know that since 1993 the Indian Health Service from an administration standpoint has had significant reductions.

These reductions are associated with increased tribal contracting, but also are associated with various reductions in administrative dollars that have occurred as a result of appropriations Acts five and six years ago, and reductions associated, as we absorbed inflationary cost increases that aren't fully funded through the appropriations process.

I would let you know that at our headquarters, as an example, there has been a 500 FTE reduction since 1993. At that time there was approximately 934 FTEs at the Indian Health Service headquarters operations throughout the country, and we are now at below 434.

A similar kind of reduction has occurred at the Area Offices which is another administrative unit.

And I have very detailed data in that regard. The actual increases in FTE for the Indian Health Service have occurred at the service level, those hospitals and those ambulatory care centers. And so on one hand we're seeing service FTEs increase and administrative FTEs go down.

The third issue has to do with the various barriers dealing with downsizing. And to be quite frank with you, I think we've been able to overcome most of the barriers that have been placed in our pathway. And we would be prepared to work with the Committee and

with the tribes as we talk about how better to right size the Indian Health Service from an administrative standpoint.

Dr. Trujillo did convene a redesign committee a number of years and we continue to follow that redesign as the Indian Health Service changes its organizational structure.

For a cost of administration programs, this is the most difficult set of questions that the Committee has raised to us. And I'm here today to let you know that we do not fully have the information available today that the Committee has requested. However, we do have information associated with the Indian Health Service program and what it costs us to administer these various health care programs.

One of the themes, Mr. Chairman and Committee members, that you should be hearing from the Indian Health Service is that we believe any and all of these activities associated with the operation of the health care program should involve tribal governments, should involve Indian organizations, Indian people. As we move forward and plan for our health care system we will need to work with the Committee, we will need to work with the tribes in more completely addressing the fourth question raised by the Committee.

In achieving the highest level of health care, we very much welcome this particular item. Basically we would like to talk about with the Committee, either at this hearing or at a later time when we can meet with your staff and provide a little more detail, as we have a number of ideas. We have a half a dozen ideas about the kind of changes that could be made in accessing third party funding streams and other revenue enhancements.

And we, again, have some details to be shared with you, some access associated with Medicaid and Medicare reimbursements, and some barriers associated with the newly approved Children's Health Insurance Program, and some Title 19 issues associated with Federal Medical Assistance payments to various organizations.

Mr. Chairman, in terms of the number 6 of the issues surrounding non-contracting tribes, I would like the Committee to know that there have been a number of innovative first steps taken by tribes, and in many instances by the Indian Health Service in partnership with those tribes, that we would also be prepared to talk about in more detail.

Noteworthy among these are activities, in Tucson, Arizona, of the Pascual Yaqui tribe, as it works with the State and with an HMO. And the successes associated with that HMO in guaranteeing a benefit package at a reasonable rate and, quite frankly, the challenges associated with continuing that particular benefits package through an HMO mechanism when the population is increasing so rapidly and costs are basically stagnant.

There are also examples where tribal governments step forward directly. There are some health insurance demonstration projects that are occurring in the country, up in the Northwest specifically. President Allen will be testifying on the next panel, but his tribe, in particular, has taken quite an innovative approach associated with providing health care services to its members.

Needless to say, the Indian Health Service project does not have authority to purchase a health insurance, if you will, as you and

I would purchase, on behalf of the Indian people. We'd be looking for some statutory assistance to allow that option to be available to us. There are a number of other activities in Oklahoma with the Pawnee benefits package and with a couple of other examples that we would like to share.

The seventh question dealt with funding needs. And especially, given the expected limitations for funding for contract support costs, we certainly appreciate the limitations and the constraints that the Congress and, quite frankly, the Administration, and tribal programs, and Indian health care programs find themselves in relative to funding. Generally, Indian health care programs are underfunded when we are compared to non-Indian programs.

What we have done as we've looked at contract support costs in developing this study, and working hand-in-hand with tribes and national Indian organizations, is that I think it's through that partnership through that working together in the budget process and on contract support costs, in particular, that the Administration has come forward with its \$35 million request.

We believe the need in FY 1999, as our written testimony states, is approximately \$52 million. That need will rise to approximately \$100 million in round numbers as we move into Fiscal Year 2000. We're certainly looking forward to working with the Committee, working with the Congress, especially in terms of also our appropriations committees. And equally as important, working in partnership with tribes in the national Indian organizations as we pursue the very important serious issues surrounding contract support costs.

Mr. Chairman, I would like to acknowledge that Mr. Doug Black, who is our director of our Office of Tribal Programs is with me at the table. But also Ms. Paula Williams, who is our director of the Office of Tribal Self Governance, is seated behind me. And if you would allow me, they are the experts in this area and I would like to depend on them for the very detailed answers to the questions that you may ask of us. I thank you for the time and I appreciate being here.

[The prepared statement of Mr. Lincoln may be found at the end of the hearing.]

Mr. HAYWORTH. [presiding] Mr. Lincoln we thank you for the testimony. And there is my good friend from American Samoa, Mr. Faleomavaega. Welcome to all those who serve on this Committee, including my good friend from Michigan and my friend from New Jersey. I want to thank you for bringing your associates this morning, and we will have questions later. Now it's my honor to introduce the assistant secretary for Indian Affairs, for the U.S. Department of the Interior, Mr. Kevin Gover. Mr. Gover, you are recognized.

**STATEMENT OF KEVIN GOVER, ASSISTANT SECRETARY,
INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR**

Mr. GOVER. Thank you Mr. Chairman. I have with me the deputy commissioner of the Bureau of Indian Affairs, Hilda Manual, and to my right, Deborah Maddox, who is the director of the Office of Tribal Services. And they will be responding if the Committee has any difficult questions.

We prepared a series of charts in response to the inquiries made by the Chairman. And the first of which is on the stand right now. [Chart]

What that shows right now is that since 1981 the Bureau has gone from nearly 17,000 employees to less than 10,000. Much of that is the result of tribal contracting. Some of the decrease is attributable to various budget cuts and the transfer of the Office of Trust Fund Management out of the Bureau. But most of it in fact is due to the increase in tribal contracting over the years.

You will also note, at the end of that chart, a slight climb in our FTEs for the year 2000. The reason for that is two fold. One, we will be adding a number of additional police officers over the next year in accordance with the President's law enforcement initiative. The other reason is that right now we are subject to a moratorium on further expanded self-determination contracting and self-governance compacting.

So the bottom line is, to those who wish to see the Bureau of Indian Affairs shrink, we must be authorized to go back to making those contracts and compacts with the tribes.

The second chart, Mr. Chairman, shows what we project our reductions will be. Now, there are certain assumptions behind that. We think we would lose a little less than 400 employees over the next few years, based on what has been happening over the past few years in terms of contracting.

That assumes a couple of things. One is that basically we'll be dealing with a flat budget. One of the things that we know is that in the years where our funding increases, tribal contracting increases. And that is only to be expected as the programs become more attractive. So, again, one of the ironies about the Bureau of Indian Affairs, the more money you give us, the smaller our agency becomes due to the tribal contracting.

The next graph, Mr. Chairman, reflects total BIA funding, the total amount contracted by the tribes, and the total amount compacted through self-governance compacts. What that shows, therefore, is that fully well more than half of our funds actually go to the tribes in the form of contracts, compacts, and grants to operate BIA schools. Again, we would like to see those first and second bars go up further so that the tribes are running even more of our program. And contract support and funding are primary impediments to increased compacting and contracting.

And this is the chart that shows why it has become difficult for us to expand the amount of contracting and compacting we're doing. As you can see, between 1995 and 1997, we lost a lot of ground in terms of contract support payments to the tribes, going from funding around 92 percent of what the statute says we owe to the tribes to only 77 percent in FY '97.

Now, we have slowly been able to increase those amounts. And were our budget request for the year 2000 to be granted, that would only bring us back to around 84 percent. So we're still far short of the mark of 100 percent.

Let me add that we too have been working with the National Congress of American Indians on trying to come up with a solution to this problem. You may also know, Mr. Chairman, that we were subject to litigation in which a Federal court determined that we

were liable to the tribes for the short fall in contract support funding, notwithstanding the fact that we've spent every dollar that the Congress had given us on contract support funding. The Court found that we were still legally responsible for the rest.

Let me mention some of the ideas that we have been talking with the tribes about and considering internally to deal with this issue. For one thing, we have now been held liable by a court for contract support to support contracts that have been let by other agencies. Now that seems to us to be questionable interpretation of the statute. Nevertheless, it's one that the courts have made. But it seems much more appropriate, given the need in Indian Country and given the continuing shrinking purchasing power of both BIA and IHS dollars, that issue be revisited and that other agencies who contract with the tribes be asked to contribute to contract support.

Second, we would propose to continue distributing contract support on a pro-rata basis. In other words, if we're only able to fund only 84 percent, say, of the contract support needs nationally, that we give 84 percent to each tribe, as opposed to all to some and less to others.

Third, we are considering the tribes' position that we should be paying certain direct costs that are associated with contracting that we do not currently pay. I think the tribes have made a persuasive case that those are appropriate costs of contracting, and we will continue to work with them to decide whether or not we'll be able to do that.

And, finally, we would like to improve our system for anticipating what our contract support costs are going to be in the future. Right now we have sort of an informal system where we ask the tribes to guess in advance whether or not they are going to be contracting with us so that we can anticipate those costs and ask for the appropriate amount.

However, under the statute, they only have to give us 90 days notice. So if a tribe decides that it wants to exercise its right, we have no way to anticipate that in a way that allows us to make it a part of our budget request. And that too is contributing to our failure to ask regularly for a sufficient amount of contract support funding.

Mr. Chairman, my time is up and we'd be happy to entertain any questions that the Committee may have.

Mr. HAYWORTH. Mr. Gover, we thank you very much for that and thank the panel for its testimony. And also, Mr. Gover, I'd say thank you for bringing your associates for any difficult questions that we might have.

[The prepared statement of Mr. Gover may be found at the end of the hearing.]

Mr. HAYWORTH. And using the prerogative as acting chairman, I just want to welcome my good friend back to the Congress from Washington state, Mr. Inslee, who is here. Good to see you. And in the prerogative of the Chair right now, I won't ask a difficult question here, but just simply for both Messieurs Lincoln and Gover. First Mr. Lincoln.

If you could offer to us what you believe to be the most essential aspect to dealing with this challenge of contract support funding

and, in a perfect world, the solution you would like to see fashioned. A chance really to amplify your statement. Let me give that to you right now.

What do you believe, in fairly short order, we in the Congress need to do to deal with this challenge? The very most important challenge we face and the solution that would be yours, if we were freed from some of these strictures we find ourselves under?

Mr. LINCOLN. Mr. Chairman, I'm going to say something that sounds very simple, that has two pieces to it, that is incredibly complex, but I think both are necessary. First of all, any solution that is crafted dealing with contract support costs, dealing with Indian health care issues, dealing with tribal solvency, and the broad set of issues that we deal with, both the Congress and the Administration, in this case the Indian Health Service, just absolutely requires working hand-in-hand at the beginning with tribal Governments. And that can be accomplished. That is something, though, that is a mandatory requirement in our mind, in the perfect world, that would be part of the response.

As that relates specifically to contract support costs. I believe that issue confronting us today really is one of funding, but it's one of funding that is as a result of the statutes and our interpretation of those statutes, if you will, the law of the land.

In the Indian Self-Determination Education Assistance Act there are requirements that the Congress has described, we think, in clear terms, regarding what the responsibility of the Federal Government is to tribal governments when they take over their health care programs, in our instance. And we believe one of those requirements, one of those essential pieces is the acknowledgement of the need and the legitimacy of contract support costs.

Furthermore, from our perspective, it is our belief that the contract support costs, as we have reviewed them, and as we have worked with tribal organizations, our own Contract Support Costs Work Group, the NCAI, and others who will work with us, those costs are not unreasonable as we look at them and as we compare them to administrative cost rates that exist elsewhere in this country with universities or with other organizations.

The answer that we need more resources is a very simple answer, and it's incredibly complex and difficult to do for all of us.

Mr. HAYWORTH. And of course it's something that it's important to get into the record because from your perspective and ours, it cannot be overstated. Mr. Gover, in preparation for your associates and the quote, unquote, "difficult questions," let me simply mention to both you gentlemen on the panel that the more difficult questions we will offer to you, we have a list prepared by the Committee staffs.

And if you could get back to us in writing within 10 days of this hearing date, we'd very much appreciate it, so that it will give you a chance to go back and ponder some of the more difficult answers.

But, Mr. Assistant Secretary, again, I'd be interested in your notion of the compelling need and the best remedy at this juncture.

Mr. GOVER. I think there are three things that really need to be done. First of all, we need to develop with the tribes a system for knowing as far in advance as we possibly can what programs they

intend to contract so that we can do proper calculations and make appropriate requests for contract support funding.

Second, each agency needs to pay its own contract support costs. The Bureau budget simply can't bear the strain of all tribal contracting with all other agencies in the government. And, third, we need 100 percent funding. We need to ramp up toward 100 percent funding of the contract support costs obligation that we've made to the tribes.

Mr. HAYWORTH. Mr. Assistant Secretary, I thank you very much and thank the panel. It may be somewhat unorthodox to my friend the Ranking Member and my co-chair of the Native American Caucus, but in closing I have my opening statement that I will submit for the record, and without objection, make that a part of the record.

[The prepared statement of Mr. Hayworth follows:]

STATEMENT OF HON. J.D. HAYWORTH, A REPRESENTATIVE IN CONGRESS FROM THE
STATE OF ARIZONA

Chairman Young, I appreciate the opportunity to participate in this important hearing on Contract Support Cost (CSC) funding. It is indeed a great honor to sit on the dais of this Committee, on which I formerly served. I would be remiss if I didn't personally thank you for your outstanding work on Contract Support Cost funding in the 105th Congress. During the waning days of the last Congress, I was pleased to work with you and others to convince our leadership to cede to our position on this issue. As part of that agreement, you expressed your intent to hold hearings on Contract Support Cost funding. I am pleased to see that you are taking this important first step.

Mr. Chairman, if you would allow me to indulge for one moment, I would also like to personally thank you for inviting to testify Lieutenant Governor Cecil Antone of the Gila River Indian Community, one of the eight tribes that I represent in Congress. I believe you will find Lieutenant Governor Antone's testimony especially compelling because although the tribe supported the eventual compromise language that was included in the Omnibus Appropriations bill, it actually lost money because of the compromise. However, its support for the compromise language was based on belief that the entire system must be fixed.

Let me take a moment to explain Gila River's predicament. In fiscal year 1999, Gila River was slated to receive their \$4 million Contract Support Cost request because they had patiently waited for more than four years and were at the front of the Indian Self-Determination, or ISD, queue. As you know, Mr. Chairman, the Administration did not include any new funding for the ISD queue. Thankfully, Congress provided an additional \$35 million for the queue and Gila River could have received their \$4 million contract. However, the tribe was willing to *lose* \$1.2 million in 1999 to fix the process and ensure that all tribes are receiving at least 70 percent of their fiscal year 1999 request. This is a far cry from the 100 percent promised to the tribe, but Gila River came to the conclusion that other tribes that are more economically-challenged should not be penalized by a system that has gone awry.

Sovereign Indian nations face unique health care challenges that make it imperative that they receive the necessary amount of funding. Native Americans suffer from diabetes at a higher rate than any other segment of our population. Some of the cumulative effects of diabetes include gum disease and amputation. Even with these added health care challenges, Native Americans receive far less than the average American in health care dollars. We need to end this, and fully-funding Contract Support Costs is an important first step.

Mr. Chairman, I have one final point to make. There is a serious dispute between the various government agencies and Congress about how much funding is actually needed for Contract Support Costs. The Indian Health Service has one set of numbers, Office of Management and Budget has another, and Congress and other groups have still other numbers. I believe that Congress needs to conduct an audit in order to get accurate data for Contract Support Cost funding. I found this to be one of the most frustrating aspects of the entire process last year. We must have accurate data in order to fully and properly fund tribes for Contract Support Costs.

Mr. Chairman, you and I represent large Native Alaskan and Native American populations. We must work now to solve the problems of Contract Support Cost

funding before more tribes lose crucial funding. I look forward to working with you and all the members of this Committee to solve this problem. I also look forward to working with Congressman Kildee, my fellow cochair of the Native American Caucus, and other members of the caucus, in rectifying the problems associated with Contract Support Cost funding.

Mr. Channan, thanks again for the opportunity to be here today.

Mr. HAYWORTH. And now let me turn to my good friend and colleague from Michigan, Mr. Kildee.

Mr. KILDEE. Thank you Chairman J.D. It's always a pleasure working with you on Indian matters. J.D. and I don't agree on a lot of other issues, but we do agree on Indian matters and our Native American Caucus, I think, has been effective. I enjoy working together on that.

Mr. Lincoln, I notice that the President's FY 2000 budget request for IHS did not propose any funding for the ISD Fund. Did IHS recommend the Administration funding for ISD?

Mr. LINCOLN. Mr. Chairman, as the budget was being formulated, and working with tribes, the tribes in the Indian Health Service did agree upon an initial request for contract support costs. That initial request was approximately \$150 million. As we were working with the tribes 9, 12 months ago, as the budget progressed through the process, the Secretary indeed supported that budget request.

And I think, legitimately, because of constrained resources, we had to pare back the request both at the Department level and at our level. Our last request that went forward, supported by the Secretary, by Dr. Shalala, was a request of approximately \$100 million for contract support costs that did include both short fall and ISD funding.

Mr. KILDEE. And what happened to that \$100 million request?

Mr. LINCOLN. I believe because of limited resources that that \$100 million amount was reduced to the \$35 million that now appears in the President's budget. That reduction was made at the Office of Management and Budget level. We had many discussions with them. We believe there were sufficient constraints in the available resources that that was one of the casualties of that negotiation.

Mr. KILDEE. At \$35 million, what percent of the tribes' needs or requests would be funded?

Mr. LINCOLN. Of the tribes that are basically on what we call our "queue," our list of pending requests, as we distribute the \$35 million that we received for this fiscal year, for FY 1999, that will essentially fund all tribes no less than 70 percent of their contract support costs needs. The lowest will be 70 percent, the average will be somewhere right around 80 percent.

With this additional \$35 million, I need Mr. Black, actually, to respond to that. There will be additional costs associated with contract support costs in the year 2000 and I do not know that off the top of my head.

Mr. BLACK. Actually, with regard to the \$35 million, what we would do, I believe, if that was appropriated, is use part of that money to fund any new contracts or compacts, assuming the moratorium on 638 would be lifted. The remainder we would use to raise that 80 percent level up and it would probably be somewhere

between 80 and 90 percent level of need funded for the tribes in the system.

Mr. KILDEE. You know, Mr. Lincoln and Mr. Gover both, you are both very good people. I know you individually and your hearts are really set on doing what's just. But I can recall back in 1981 when President Reagan became President, and he appointed Cap Weinberger as Secretary of Defense, and Dave Stockman as his Director of OMB. Now, Dave Stockman went down to all the other agencies and slapped them around and told them to reduce the amount of their request, and Dave Stockman usually won.

But when he went to Cap Weinberger, Cap Weinberger told him to go to heck. He really became an advocate, a strong successful advocate of the Department of Defense. And you two, I know you are good advocates, but I just encourage you to become just get a little meaner in there when the OMB comes to you.

Dave Stockman ran the government back in 1981. Except he couldn't run Cap Weinberger because Weinberger would slap him in the face and say, "Go back to your office, kid, we're going to get this amount of money for defense."

And I think that with all my high regard, and I do have it for both of you, I think you really have to look back and take a page out of Cap Weinberger's book and say, "We're going to tell OMB to go the heck and we're going to demand more," and become a strong, successful advocate for these programs.

And I know you have in your heart to do that. I just give you that advise, not as criticism, because I know you really believe that. But read Cap Weinberger's biography. He was good at pushing Stockman around. Thank you. And thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Kildee. Let's turn now to my good friend from American Samoa.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman. It's always a personal welcome to see the assistant secretary of Indian Affairs here with us in the Committee. Secretary Gover and our good friends also from the Indian Health Service, I do have a couple of questions and maybe one basic observation that is somewhat at a loss.

Basically, this year the Administration has requested only \$168 million for Indian Health Service contract support costs and yet we need about \$250 million to really do the job in a better way. Am I correct on this?

Mr. BLACK. The Administration has actually requested a \$35 million increase to a \$203 million base in 1999. So the request is actually \$238 million for contract support costs in 1999—2000, excuse me.

Mr. FALEOMAVAEGA. Okay. Do we need an authorization to increase the level of what you need as far as what the authorizing committee is concerned?

Mr. BLACK. No. No, we don't believe an authorization is needed. In fact the 638 law speaks to the necessity of funding these types of costs at 100 percent. It's just a matter of having sufficient appropriations to do so.

Mr. FALEOMAVAEGA. Now, do you get the sense that this is also the reaction from the appropriations committees, that we're on the right level of funding? Because the information I have here is the

appropriations committees do not agree with your assessment. You are only asking for \$168 million, and yet for the unmet needs we need to come up with about \$250 million. Is the information I'm reading wrong as far as you are concerned?

Mr. LINCOLN. Yes, Congressman. The amount of funding that we actually have available this year is \$203 million, as Mr. Black said. And we're requesting an additional \$35 million to bring it to \$238 million. We believe the Appropriations Committee, in our discussions with the committee, is concerned with a number of issues associated with contract support costs.

One of their concerns that has been expressed to us in various ways is the increase in the need for additional contract support costs based upon, though, an analysis that has been performed working with tribes. But also an independent analysis that we've done, we believe the increased need for contract support costs is primarily based upon the increased contracting that is occurring out there. And so more and more of the program is coming under contract, and therefore the need for contract support costs is increasing.

Mr. FALEOMAVAEGA. So in your opinion, you don't need any help from this Committee as far as authorization is concerned?

Mr. LINCOLN. To the extent that this Committee can make known the issues associated with contract support costs, including the requirement and estimated need for resources, that would be very helpful.

Mr. FALEOMAVAEGA. You are losing me, Mr. Lincoln. Tell me the bottom line, how much to you need?

Mr. LINCOLN. In year 2000, we estimate that the Indian Health Service would need an additional \$100 million to the \$238 million, in round numbers.

Mr. FALEOMAVAEGA. Now, do you need an authorization?

Mr. LINCOLN. No, we do not. We believe we have the current statutory authorization. We need the appropriation.

Mr. FALEOMAVAEGA. Well, I'm glad to hear that because I'm just a little upset about the whole process, Mr. Chairman. And not taking anything from the sincerity of our friends here from the Indian Health Service, but it's so easy for us to find \$18 billion to bail out the financial crisis in Indonesia with a corrupt dictatorship and fraud and nepotism and corruption, billions to help Korea, billions of dollars to bail out Bosnia, and yet we always seem to be trying to look for crumbs to help the indigenous Native Americans in their needs. To me that's an insult.

But I sincerely hope, gentlemen, that the piece of paper I have before me is wrong in its assessment, that we're not short in funding the IHS contract support costs. I'm very happy to hear this.

Mr. Gover, you mentioned that over 50 percent of the BIA funding goes to the tribes?

Mr. GOVER. That's correct.

Mr. FALEOMAVAEGA. So how much of the administrative cost of the total budget goes to the administration then?

Mr. GOVER. Of BIA's total?

Mr. FALEOMAVAEGA. Yes.

Mr. GOVER. We believe it's less than 10 percent. I would have to go back and do some work to get you a number.

Mr. FALEOMAVAEGA. Does this mean the decrease of the employees now, the BIA, from 17,000 to 10,000, it also means a decrease of everything else the BIA needs?

Mr. GOVER. There has been a sharp decrease in the BIA in almost every program. Both the tribes' contract as well as our administrative function. We too were subject to a dramatic riff in FY 1996.

Mr. FALEOMAVAEGA. Now, you mentioned that there should be an increase on contracting for self governance, that's your recommendation?

Mr. GOVER. Absolutely.

Mr. FALEOMAVAEGA. How much do you think we need to have on that?

Mr. GOVER. To get the tribes to contract all these programs?

Mr. FALEOMAVAEGA. Yes.

Mr. GOVER. The first step is definitely 100 percent funding of contract support. After that, we actually have to begin doing some real needs assessments in the communities. What is it the tribe really needs, and what would it take to get them to assume the responsibilities that we now have? A lot of tribes look at our programs and say, "Look we don't want that responsibility because this program isn't funded enough."

Mr. FALEOMAVAEGA. The problem we're having is—sorry, Mr. Chairman.

Mr. HAYWORTH. That's okay. The gentleman's time has expired, but he has identified some real areas of concern. And given the fact that there is a vote on the floor now, we would ask the indulgence of the panel and other members of the Committee. We will take a short recess and resume following the vote so members should return as quickly as possible.

And we thank the panel's indulgence, and I thank my friend the delegate from American Samoa. The Committee is in recess pending completion of the vote, and will return here to the Committee chambers.

[Recess.]

Mr. HAYWORTH. Mr. Inslee, you have the floor to ask questions of this panel. And thanks for coming back as rapidly as you did.

Mr. INSLEE. Thank you, Mr. Chairman. Somebody has got to hold the fort, so to speak.

Mr. HAYWORTH. That's right.

Mr. INSLEE. Thanks for coming and it's good to see you. You are in a difficult position because many of us would like to see us move forward on self determination and are very concerned that these budget numbers are effectively stymieing that policy. And I think that you know that's a pretty strongly held position, that we do need to move ahead on self determination.

And we hate to see anything stand in our way in that regard. And you are in a difficult position because you are not the ultimate decisionmakers but you are the ones that are here today. And I guess the question is, is it a fair statement to say that these numbers that we are looking at, that this effectively stymies the intent of the self determination that Congress has, I think, repeatedly evinced as our public policy?

Mr. GOVER. Mr. Chairman, I think it's fair to say that the primary impediment to the full implementation of the self-determination and self-governance policies is appropriations to the Bureau.

Mr. INSLEE. Right.

Mr. GOVER. That if we could get these programs up to a point where they are really beginning to achieve some of the things that they are desiring to achieve, then the tribes will be much more interested in taking on even more responsibilities than they have.

I don't think they are particularly interested, nor should we be in seeing them take over these responsibilities, only to fail. So, yes, if we got the kind of funding that actually addressed the extent of the need out there, our agency would become really quite small and tribal governments would take over these responsibilities.

Mr. INSLEE. During the appropriations discussions, during the process, have you heard rationales for not fully funding this clear policy of the U.S. Government? I mean what rationale is there other than—I'd like to hear it. I've so far not heard it articulated.

Mr. GOVER. There are competing priorities. I should say, first of all, that this is the first year, that I'm aware of that this Administration has proposed substantial increases for both BIA and IHS. Our request is about 9 percent above FY 1999. I think it's about the same for IHS. So both agencies fared reasonably well in the process this year.

What's so frustrating is a big increase, what appears to be a big increase, especially of a time of what's supposed to be a flat budget environment, still doesn't begin to address the need that we know exists in Indian Country. And so even numbers that seem large are small when compared to the need in Indian Country.

Mr. INSLEE. I guess what's really bothersome is there are a lot of needs in our country, they are infinite in describing needs, but this is one that has been determined to be a policy of the United States government. And it's very painful to see the United States government not fulfilling that policy commitment.

And I guess, for whatever good or help it does to you, I hope that you will let everyone who knows, and I recently worked with HHS and had a good experience there, that's there a high temperature here, at least among quite a number of members that this is a very, very important thing to us and we put a high level of interest in it. And we're going to work with you through this budget process to try to fulfill this commitment. Thank you.

Mr. YOUNG. Mr. Lincoln? Do you want to be recognized to give me an accurate number that you misquoted? I didn't even know it. You got away with it as far as I'm concerned. Go ahead.

Mr. LINCOLN. Mr. Chairman, I very much appreciate the opportunity. I was asked what the 2000 need was for the contract support costs in the Indian Health Service. The number I gave was approximately \$338 million. The correct number is \$309 million. And we know the Committee has asked for projections of need, and we'll make available the detail to back up those numbers, sir.

Mr. YOUNG. A member had a question, and where is he? We'll just wait for a minute here. Where is his staff? Would you get hold of him? Or I'll ask his question, one or the other. I'll fill in some time and ask some questions. How is the weather outside?

Assistant Secretary Gover, the Indian Health Service has provided the Committee with detailed tables setting forth each tribal contractor's program funding level, contract support cost needs, by category of contract support, and FY 1999 contract support payment being made against that need.

Could the Bureau please provide the Committee the same detailed data we have received from the Indian Health Service on individual tribal contract support needs, with each need area and its anticipated FY 1999 payments? Long question.

Mr. GOVER. Mr. Chairman, we will do so. We have sent you FY 1998. FY 1999 is being prepared even as we speak.

Mr. YOUNG. Okay. The Indian Health Service recognizes tribal needs for direct contract support, primarily to cover personal associated expenses not available to the agency for transfer to a tribe. Why has the Bureau never before recognized tribal needs for direct contract support costs in addition to indirect costs as the Indian Health Service has done so?

Mr. GOVER. I don't know why it hasn't in the past but as we addressed in my statement, in my oral testimony, we are considering that. Basically, through the process with NCAI and with IHS over the past year, we've become persuaded that this is quite likely an appropriate cost for us to pay.

Mr. YOUNG. I have been asked to submit a question by the gentleman from Hawaii. And I so in writing and you can answer directly to him. With that, if there is no more questions of this panel, I'll dismiss the panel. And, thank you, for your directness and I hope we can go forth and solve these problems. Thank you very much.

The next panel is Mr. Ron Allen, president of the National Congress of American Indians; Mr. Orie Williams, executive vice president, Yukon Kuskokwim Health Corporation, Bethel, Alaska; and Lt. Governor Cecil Antone, Gila River Indian Community, Sacaton, Arizona.

And I am going to allow Mr. J.D. Hayworth to chair the meeting. And Mr. Williams and I discussed his testimony and I'm quite pleased and enamored with it. And we'll solve these problems, but I have another meeting I've got to go to, so Mr. J.D. will take over. I appreciate it.

Mr. HAYWORTH. [presiding] And as we get the appropriate labels attached to the appropriate guests, and guests on the Committee dais as well, we will begin. Mr. Allen, we'd be happy to have your opening statement, if you please, sir.

STATEMENT OF MR. W. RON ALLEN, PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

Mr. ALLEN. Are you calling upon me, Mr. Chairman?

Mr. HAYWORTH. Yes, sir. We'd be happy to have your statement.

Mr. ALLEN. Mr. Chairman, on behalf of the National Congress of American Indians, it's a pleasure to be here and testify and share some observations along with my colleagues with regard to the contract support issue. You have our testimony for the record and accompanying it is a couple of reports on the progress that we've made with regard to this topic.

We want to begin this discussion by saying that the Self-Determination Act passed in 1975 essentially made a commitment to empowering tribal governments. And we have made substantial progress. And today, in 1999, the issue here is a topic that causes us a great deal of frustration with regard to contract support. You know, we have spent a great deal of time eliminating the paternalism and forced dependencies and the patronizing bureaucratic ways of dealing with Indian affairs that we have witnessed for decades. And we have now seen tribal governments begin the process of becoming fully empowered and capable governments to manage their own affairs as we move forward today.

In terms of taking over Federal programs, we eventually started to grow in our capacity and started to ask the fundamental question, how much of the Federal system should we be taking over and how much should be left in order to administer what we would call "inherent Federal functions." We firmly believe that we are moving forward with greater autonomy and with responsibility and accountability for these resources.

The contract support component of this issue is one that causes us a great deal of frustration because it is a policy, a Federal policy that is inconsistent. We believe that if you look in every corridor in which the Federal Government administers contracts with different entities out there, whether it's educational institutions, or even within the agencies and departments in the Federal Government itself, you will see that they fully pay these consistent and similar costs for those entities.

You would never underfund the educational institutions out there, you would never underfund the administrative costs for defense contractors, you never underfund yourselves when you transfer funds back and forth between agencies and departments. And I would footnote, the rate that you share these costs back and forth when one agency does something for another agency averages around 48 percent.

The average rate for contract support expenses and indirect cost rates for Indian Country is around 25, 26 percent. So we aren't even at the same level of the rate of recovery of cost as you see elsewhere throughout the Federal system. The issue for us is how are you going to administer these costs with regard to the programs and activities that we're taking care of?

So as we take over more Bureau programs, as we take over more IHS programs, these costs, the indirect costs, the direct contract support costs, the start up costs for taking over these functions are all legitimate costs. They are all straightforward costs, they are established by rules that the Federal Government establishes, negotiated by the Federal Government, so there is nothing wrong with these costs.

The thing that's frustrating for us is that when you underfund and you've been underfunding for two decades, for two decades you have been underfunding us, it means that when we take over these Federal programs, we are subsidizing with our limited dollars Federal Government programs, the programs that you are responsible for in serving our people.

And we find it very frustrating, the notion that the Congress or the Administration says we've got to make priorities in terms of

what we can pay for means we can only pay for so much of this and so much of that. But when you take over these programs, these are costs that come with it. And in 1994, as the previous panel noted, it recognized that you will not underfund us. That you will not continue to underfund the tribes with regard to the contract support. Can you resolve the underfunding of tribes with regard to Federal agencies outside of the BIA and IHS which are the two primary funding agencies? So the frustration for us is that is absolutely outrageous. The number is outrageous. If you got around \$4 billion between these two agencies alone, it's a little over \$4 billion, the issue to us is that you are telling us that another \$150 million is too high a price to pay for the empowerment of tribal governments.

And our point is if we're going to advance devolution—"devolution" means that we are empowering the local governments to take care of the community needs—if it works for the states and local governments, why doesn't it work for the tribes? The tribes, you know, can take care of their people and manage their resources.

So the issue with contract support is that if you take away from these hard costs it means that you are eliminating direct services. That's what you are doing. Whether it's health care services, enforcement services, natural resource management services, travel costs, and so forth, and programs that advance the welfare reform legislation, then you are cutting away from those programs to address those needs in our communities. They are paying for these hard costs for facilities and basic accounting responsibilities, et cetera.

So we're pointing out that we're working with the Administration and we want OMB to own up to this responsibility and quit rationalizing. It is a dry topic, we acknowledge that. But it's a topic that we can understand. It's a topic that we can show you in layman's terms how it works and why it's legitimate. And Congress needs to own up to that responsibility so we are asking you to work with us.

NCAI has a task force. We will present you a report in April and that report will show what we believe is constructive solutions for resolving this issue. Thank you.

Mr. HAYWORTH. Mr. Allen, we thank you for your testimony. We look forward to the report, and we thank you for your candid comments which many of us here share and are happy to hear.

[The prepared statement of Mr. Allen may be found at the end of the hearing.]

Mr. HAYWORTH. Let me call upon the gentleman to whom our Chairman alluded, before he had to exit, his good friend from Bethel, Alaska, Mr. Williams for his testimony.

STATEMENT OF MR. ORIE WILLIAMS, EXECUTIVE VICE PRESIDENT, YUKON KUSKOKWIM HEALTH CORPORATION, BETHEL, ALASKA

Mr. WILLIAMS. Thank you, Mr. Chairman. I'd like to introduce Mr. Lloyd Miller, Esquire, who is a renowned tribal attorney who has helped our tribe and others across the Nation deal with this issue and many, many others. I'd also recognize Ken Brewer, in the audience, a chief executive officer from SEARCH, who has worked

on contract support for years, on the technical and accounting parts.

Good morning, Mr. Chairman, and honorable Committee members. My name is Orie Williams, and I am the executive vice president of the Yukon Kuskokwim Health Corporation, based in Bethel, Alaska. Thank you for the opportunity to testify this morning on what Congress 10 years ago called the single most serious problem with implementation of the Indian health information policy. Namely, the failure to fully fund contract support costs.

YKHC serves as a consolidated health care provider for 58 federally recognized Alaskan native tribal governments, spread across a roadless area the size of South Dakota. Poverty and poor health have led some to compare conditions in many of our villages to those faced in Third World countries.

Indeed, over 50 percent of all our tribal members are Medicaid eligible. In many of our villages the unemployment rate exceeds 80 percent. And most of our village homes use six gallon plastic buckets for toilets. You may have heard them referred to as "honey buckets."

Prenatal mortality is more than double the average of the U.S. rate. Death by suicide is four times the national rate. Fetal alcohol syndrome and fetal alcohol effect are rampant. And the lack of adequate sewer and water systems has left our communities victim to every known infectious disease and higher rates of tuberculosis, even as we enter the 21st century.

Our tribal governments, working together to maximize the opportunities available under self-determination and self-governance, are meeting the many challenges we face through the direct administration of 47 village clinics, one mid-level sub-regional clinic, with two others under construction, a 51-bed hospital, and over 1,000 employees operating with approximately \$40 million in Indian Health Service funding.

We have done much to improve the delivery of health care services since the days of Indian Health Service administration. But the contract support shortfall we face of over \$2.3 million consistently cripples our ability to do more. As my written testimony details, the shortfall has meant deficiencies in our accounting department, our billing and admissions department, our technology support, and our hospital and facility maintenance.

In addition, the short fall has required us to transfer funds from key programs, and has not allowed us the flexibility to enhance our substance abuse and mental health services, home health care for the elderly, village clinic operations, and to promote disease prevention and health education. To those who are unfamiliar with health care conditions in rural Alaska, our deficit is just a number. For us it is having a real impact on the quality of health care in general.

Having contracted the operation of health care programs in the Yukon Kuskokwim Delta since the mid-1960s, we have the following recommendations to offer the Committee as it examines the contract support costs system. First, the system itself is not broken. So, please do not give in to the temptation to replace it with something new. It is a system that works well for determining each tribe's necessary requirements to transfer and carry out Indian

Health Service's health care programs. In 1988, the Committee closely scrutinized the entire contract support system and came up with only one recommendation for fundamental change. The system must be fully funded. In 10 years that has not changed.

Second, the Committee would reject persistent calls for change in the underfunded Indian Health Service contract support system by a flat pro rata approach. That proposal, considered and properly rejected last year, would have only made our own situation worse, causing massive layoffs and instability. Yes, it is true that the underfunding across Indian Country, is for a variety of reasons, uneven, but the answer is not to reallocate the misery among the Nation's tribes, the answer is to meet the Country's obligation to all the Nation's tribes.

Third, we agree with the Committee's concern that despite vast improvements in recent years, the Indian Health Service must still do more to downsize and transfer to tribes both headquarters resources and many of the resources in the area offices.

Not everybody in the Indian Health Service system fully embraces the self-governance process, and the bureaucracy therefore often misuses such concepts such as "residual", "inherently Federal," "transitional," and "business payment plan." More often than not, these are simply phrases and devices used to protect the Federal bureaucracy from being transferred to a tribal operation.

Fourth, we ask the Committee to remember that the Indian Self-Determination Policy was initially designed and announced by President Nixon, not as a means of saving the Federal Government money but as a way to end Federal paternalism and promote tribal accountability and responsibility. Congress and Indian Health Service and the tribes will fall short of that goal if our focus becomes preoccupied strictly with a cost accounting of how much the system costs to operate and why there are differences in those costs.

Fifth, to make the self-determination policy as efficient as possible, Congress should promptly enact the permanent self-governance legislation that passed the full House last year as H.R. 1833. In addition, IHS should expand to all tribes the so-called "base budget" multi-year funding approach, so the tribal savings and administrative overhead remain available for program delivery.

Sixth, let us build on the success that we have already achieved by opening the door to permit tribes to contract over non-Indian Health Service health care programs currently operated by the Department of Health and Human Services. Enacting Title 6, the Indian Self-Determination Act again, as proposed last year, in H.R. 1833, will help us lay the ground work for achieving greater economic efficiencies in health care, as tribes bring more and more programs together.

Similarly, extending the Medicare and Medicaid demonstration program, as proposed in S. 406, will allow us to more efficiently bring in third party resources so that the level of care being funded across Indian Country can be enhanced.

We are thankful to the Committee for once again focusing Congress' attention on contract support costs. At long last the system must stop punishing tribal health care providers that take up the

self-determination and self-governance challenges to operate Indian Health Service programs.

I say “punish” because if a tribe or tribal organization wants to operate an Indian Health Service program, if it wants to take on the responsibility for the health of its people, if it wants to break the cycle of paternalism and dependency, there is a price; The tribe must finance the government’s underfunding of contract support directly out of program funds. Congress does not ask this of the Department of Defense contractors, and Congress certainly should not ask it of tribal health care providers.

We believe the Indian Health Service’s new estimates for fully funding the contract support system are conservative and achievable in this fiscal year. We also believe that restoring the Indian Self-Determination Fund to between \$10 million and \$15 million a year may be sufficient to meet the average rate of growth the Indian Health Service anticipates in the years ahead.

Self determination and self governance work and other tribes should be encouraged by Congress to move forward as we have in Alaska. Tribes and tribal organizations should not be told we must wait one, two, or more years either to operate a program or to receive contract support for a program. And we should not be told we can only operate a program if we agree to perpetual underfunding in our contract support costs.

Thank you Mr. Chairman, for the opportunity to testify today. YKC looks forward to working with the Committee, the National Congress of American Indians, and the Indian Health Service to improve the Indian Self-Determination and Self-Governance Acts.

Finally, we extend an invitation to the Committee, the Committee members, their spouses, and staff to visit us in Alaska in the Yukon Kuskokwim Delta region. We would like to share with you the sights of our great state and the hospitality of our people, and have you witness first hand our villages and our efforts to improve the health of our people. I pray for you and your families, the best of good health.

Mr. HAYWORTH. Mr. Williams, we thank you for your testimony and for your invitation. As my friends from Arizona will attest, especially in the summertime, round about August, it gets pretty hot on the desert floor and we think the climate would be a marked contrast in the great state of Alaska. So thank you for that kind and generous invitation, as well as your testimony.

[The prepared statement of Mr. Williams may be found at the end of the hearing.]

Mr. HAYWORTH. Again using the prerogative of the Chair, last but not least, I’m pleased to call on one of my constituents. And by way of introduction of this particular gentleman, let me simply point out something that has already been included in the record but I need to articulate.

As my colleague from Michigan and my friend from American Samoa will attest, the whole issue of contract support costs was something that we worked very closely together on a bipartisan, indeed, a non-partisan basis to make some profound changes in the closing days of the 105th Congress.

My friends from the Gila River Indian community in dealing with this matter, as an additional \$35 million was provided for the

queue, Gila River could have received its \$4 million contract. But I think this was significant. The tribe was willing to lose \$1.2 million in 1999 to fix the process and ensure that all tribes are receiving at least 70 percent of their FY 1999 request. That's a far cry from the 100 percent promise to the tribe.

But Gila River came to the conclusion that other tribes that are more economically challenged should not be penalized by a system that has gone awry. It is that type of responsibility and response to challenges that typifies the Gila River Indian community and my good friend Lt. Governor Cecil Antone, from Sacaton, Arizona, who will offer his testimony now.

Mr. Lt. Governor, we welcome you and we thank you, and we look forward to hearing your testimony right now, sir.

**STATEMENT OF LT. GOVERNOR CECIL ANTONE, GILA RIVER
INDIAN COMMUNITY, SACATON, ARIZONA**

Mr. ANTONE. Good morning, Mr. Chairman, members of the Committee. My name is Cecil Antone. I am the Lt. Governor of the Gila River Indian Community. In the audience today is Mr. Pete Jackson, who is the chairman of the Gila River Care Corporation, along with one of our council members that came yesterday and is here for the hearing, Councilman Earl Lara. I'd like to recognize them.

Our community is located on 772,000 acres in south central Arizona. Our community is comprised of 19,000 tribal members, 13,000 of whom live within the boundaries of the Reservation. We have a young and rapidly growing population that presents us with a variety of current and future health care challenges.

Our community is fortunate enough to have a hospital on the Reservation. Its program's services in and of themselves are not enough to serve the entire community. Our Public Health Department provides health care services to our tribal members. Our community's experience with contract support cost funding exposes some of the weaknesses of past funding practices. It also illustrates, however, that significant rewards can result when Indian tribal governments embrace the self-determination policy articulated in the Indian Self-Determination Act by taking over our operation of health care programs.

Our community has expanded and improved services since assuming local operation and management of health care services throughout our Department of Public Health and the Gila River Health Care Corporation which operates our hospital. We restored services that IHS was forced to eliminate due to inadequate funding in the early 1990s. We have changed aspects of our health care delivery system which has resulted in increased outpatient visits and redirection of services to target our community's most serious health needs.

We have made these improvements despite operating our hospital for more than three years with no contract support cost funding whatsoever. We are also beginning to convert the Department of Public Health from an underfunded and overworked tribal health care agency to a public agency we believe can rival the best of local and state programs. These tremendous strides in health care service improvements by our community have been made at

the same time a significant cost savings have been achieved through the assumption of local operation of administrative functions.

Despite these improvements, our total funding of the hospital only provides approximately \$1,400 per patient, well below the national average of \$3,000 per patient. Underfunding contract support costs is a significant factor in keeping our funding per patient so low.

Every contract support dollar that we have been short changed is one less dollar that we can spend on health care services over the past three years that we have been operating our hospital. The hospital has had to absorb over \$10 million in unfunded contract support costs. As you can see, these dollars would have made a significant impact in bringing per patient funding closer to the national average.

We need a firm commitment from Congress and the Administration that they will maintain 100 percent funding for contract support services for the future. This is the central theme of my testimony today.

Now I would like to briefly address certain of the issues that have been raised in the Committee's letter to Dr. Trujillo. First, we support Federal legislation that would provide a reduction in IHS administrative costs, consistent with the goals of Indian self determination, so long as the diverse and unique needs of all Indian tribal governments are considered.

Second, we strongly support legislation to make self determination permanent within IHS. We appreciate the Chairman's leadership in inducing and securing passage in the House of H.R. 1833, in the 105th Congress. And we look forward to supporting similar efforts in this Congress. Clearly, it is vital to the policy of self determination that Indian tribal governments have the continued right to enter into self-determination contracts. We strongly support lifting the 638 contract moratorium applied by Congress this past year on any new and expanded 638 contracts. The moratorium is a direct affront to the right of self governance and self determination provided to Indian tribal governments under Federal law.

Fourth, we encourage Congress to remain committed to increasing contract support costs not only within the IHS budget, but also within the Bureau of Indian Affairs budget. In addition, any proposed Congressional solution to contract support costs must address contract support costs within IHS and the BIA in a consistent manner.

In conclusion, what our story demonstrates is that the self-governance framework can build tribal administrative capacity, reduce bureaucracy, save money, and most importantly improve the quality of health care services to tribal members.

And with that, I would like to ask unanimous consent that my full statement be entered into the record. I would now be pleased to answer any questions the Committee may have.

But in addition to that, Mr. Chairman, I'd like to recognize yourself for all the hard work that you have done throughout the years in representing the Gila River Indian Community in Congress, as well as other tribal nations throughout this country.

Mr. HAYWORTH. Mr. Lt. Governor, I thank you for those kind words. Without objection, the remainder of your statement will be included in the record, and that goes for everyone who has joined us here today, for their written statements. But, again, I thank you very much for those kind words.

Let me begin Lt. Governor Antone, with a question for you. It may interest all those who joined us today to understand the extent to which diabetes is a serious problem within your tribal population. And I'd like you to first of all to talk about the nature of the problem. And, also, if you could address the question, how does contract support cost funding relate to that issue of the incidence of diabetes among your community's population?

Mr. ANTONE. You are absolutely right, Mr. Chairman. Our community has the highest incidence of diabetes in the world, and it is a significant health care problem in our community including among our children. I know you have been a champion for fighting juvenile diabetes because we have worked with you on issues in the past and we will continue to work with you on the same issue in the future.

Taking over health care programs has allowed us to focus on our community's most serious health problems such as diabetes. We have been able, for example, to reduce the rate of foot amputations relating to diabetes significantly by placing two podiatrists at our hospital on our staff. The decrease in foot amputations is just one example of how funding to run our health care programs is improving the outlook of diabetes patients in our community. Even with this progress however, we are still so far behind that it remains our top health care issue. Every contract support dollar that we don't get reduces the money that we can spend on the diabetes care. Conversely, every dollar we do get goes into improving the health of our community members.

Mr. HAYWORTH. Lt. Governor, thank you for your testimony. I was privileged to have two members of Congress from both sides of the aisle join me on a tour, as you know, of your community in the past weeks, and visiting your health care facilities. But as you pointed out, as we have seen, your community has found ways to improve health care services while absorbing millions of dollars in additional costs each year due to inadequate or absent contract support costs funding.

In your mind and through your experience, how was your community able to achieve those improvements?

Mr. ANTONE. Mr. Chairman, as a result of contracting with IHS under the Indian Self-Determination Act, we have found that once we were not burdened by bureaucracy we were able to make much more efficient use of program dollars that were formerly under IHS control. We found not only could we stretch these dollars further and gain significant cost savings, but we also could create a better quality health care service by tailoring our programs to the unique health care concerns of our tribal population, and most importantly, the disease of diabetes.

Mr. HAYWORTH. Mr. Lt. Governor, in your opinion, is the queue system of allocating contract support costs funds preferable, if it means getting 100 percent funding later rather than 70 percent funding earlier?

Mr. ANTONE. Mr. Chairman, although we would have received 100 percent last year if the funding procedures related to the queue had remained the same, the queue system is very problematic for tribes. There is no predictability with respect to how much funding will be available each year, how long tribes will have to wait for new funding, and how long it will take to get to 100 percent funding.

The fact is, however, Indian tribal governments should not have to make the choice at all between some funding early or more funding later. Ongoing and recurring contract support cost funding is Federal policy.

The real issue is getting Congress to realize that those funds promised to tribes must be appropriated in full and recurring amounts. Anything less than full and recurring appropriations for all contract support cost funding needs is an abdication of Congressional responsibility toward Indian tribal governments.

Mr. HAYWORTH. Mr. Lt. Governor, as I pointed out in introducing you, the Gila River Indian Community was willing to really step forward and make a sacrifice. Let me ask you again, to follow up on that, would your community be willing to sacrifice 100 percent contract support costs funding so that all tribes could have funding levels raised to, for example, about 80 percent?

Mr. ANTONE. Last year our community was fully expecting to receive 100 percent of its contract support costs needs because we had waited patiently for four years to rise to the top of the ISD queue. In light of FTEs \$35 million in new funds made available for the ISD queue last year, however, we agreed to a proposed allocation of those funds that would strive to give all tribes on the ISD queue 70 percent funding.

Mr. HAYWORTH. Mr. Lt. Governor, we thank you for your comments and for the efforts of your community.

[The prepared statement of Mr. Antone may be found at the end of the hearing.]

Mr. HAYWORTH. Let me turn now to my good friend from Michigan for any questions that he may have for the panel.

Mr. KILDEE. Thank you, Mr. Chairman. First of all I'd like to thank Ron Allen and Lloyd Miller for participating recently in the caucus briefing we had on support costs. That was very helpful. We had about 40 staff members there, including a member from the Subcommittee on Appropriations, so it was very helpful.

As a matter of fact our Native American Caucus has grown from 55 members last year to 74 members this year from both parties, so we are going to become more proactive. And your participation in that briefing was very, very helpful and will lay the groundwork for that. Also, Lt. Governor Antone, please give my greetings to Governor Murray Thomas. I've enjoyed visiting your Nation out there. Having grown up wanting to be a fireman, I was captivated by your fire department out there. I spent more time in the firehall talking to the fire fighters, but it was very interesting.

And whether we have a queue system or pro rata the whole thing will be solved if the United States Government obeys the law passed in 1975. We have broken treaties and we've broken the law. And we don't really need an authorization for that because that

was in the 1975 law, the appropriations and the budget process, to call for that money.

And I certainly will begin to increase my pressure on the Executive Branch of Government. We have now a surplus in the budget, no longer a deficit. We're saving most of that surplus for Social Security and Medicare. But certainly we can find the dollars for our commitments to the Native American Nations in this Country. And I will increase my advocacy for that. And we need your help in doing that, and you've already helped. I just appreciate all your testimony here today and look forward to working with you. Thank you.

Mr. ANTONE. Congressman Kildee, Mr. Chairman, I appreciate your kind words and I'll relay the information to Governor Thomas.

Mr. HAYWORTH. Thank you Mr. Kildee. The gentleman from American Samoa.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman. I'm sorry that I wasn't able to follow up with a couple of questions I had with a previous witness but I certainly welcome our panel members.

Mr. HAYWORTH. If the gentleman will yield? If my friend from American Samoa would like to submit those questions in writing?

Mr. FALEOMAVAEGA. I definitely will.

Mr. HAYWORTH. Without objection, it is so ordered.

Mr. FALEOMAVAEGA. And my good friend Ron Allen, there are some 500 tribes currently in United States, Mr. Allen. How many do participate in this contracting program of self governance? Do you have any idea?

Mr. ALLEN. Well, it's probably in the neighborhood of 325 to 350 that are contracting or compacting.

Mr. FALEOMAVAEGA. And in your opinion this has gone very well since it's been implemented?

Mr. ALLEN. Well the contracting movement, in terms of taking over the programs has been very constructive because the tribes have wanted to take over these programs and services and manage them for themselves according to their own governmental priorities, and so that has been moving forward. And the contract support issue and the notion that it's out of control has become a new kind of political impediment.

Mr. FALEOMAVAEGA. Do you agree with the Administration's assessment in terms of the proposed budget? I had outlined that the Administration had actually requested only \$160 million and they disagreed. And they are actually requesting almost \$250 million for this contract services program. Is that in line with your underfunding of the budget proposal for FY 1999?

Mr. ALLEN. Well, I guess it's about, somewhere around \$240 million, just under I think, for next year, FY 2000. And they had revealed that there is a need for an additional \$100 million and we concur with that. One good thing about IHS is on their side of the aisle they have done a good job in getting more accurate data.

Their data is pretty accurate now in terms of how many contracts are out there and what that level of shortfall is both from those that are new programs by tribes, or new tribes that are taking on programs, as well as the shortfall for existing contracts and shortfalls in start up monies as well.

One other factor that was weighed into that number they gave you is that it's an inflationary adjustment. And you know the Federal Government gives COLA adjustments, inflationary adjustments all the time. Unfortunately, we never get them. And they'll come up with a rationalization of why they shouldn't do that.

So we're urging IHS and BIA, as they make their projections, to insert that inflationary adjustment because the cost of securing those services is increasing.

Mr. FALEOMAVAEGA. So in your best assessment, whenever we talk about Indian funding, there has never been any indexing done as far as adjusting for inflation?

Mr. ALLEN. No, it's not adjusted. Basically, all they are doing is taking the raw numbers and transferring them over to the next year, and then adding whatever they can justify for additional increase in CSC numbers in conjunction with the ISD Fund. It was pointed out earlier that the ISD Fund, which is for new contracts, needs to be reinstated in IHS. It is on the BIA, and it does need to be reinstated on IHS to accommodate those new contracts.

Mr. FALEOMAVAEGA. I know we do it for the Department of Defense and for other Federal agencies but not for the Indian Services. I'm very surprised. Mr. Williams, I enjoyed listening to your testimony about the problems affecting Native Alaskans. Do I understand that of the program under the Indian Health Service, do the Native Alaskans have a separate Indian Health Service program, or are you all grouped in it together with the continental Native Americans?

Mr. WILLIAMS. We're all under the same system. We're part of the United States, as I'm sure you are well aware, but are all under the same system. The Alaskan area has their own area office which, as of January, is all contracted. In YKHC's case, we've contracted everything available to us. In the State; under the demonstration, the 226 tribes have come together under one compact with Congress, with the United States, under the same system and criteria as other tribes in the continental United States.

Mr. FALEOMAVAEGA. So your program is little different structurally because of the way the—

Mr. WILLIAMS. It's 58 individually recognized Federal Governments that have come together because of their size and ability to generate the funds and work together to get the best efficiency out of the funding that we do have. These are very small tribes; we have 58, the largest one is about 3,000 members and the smallest one might be 48 members. So for economy of scale they have joined together under one agreement.

And they tribally elect their board members. The tribes elect the people that make the priorities on the health care delivery system. Then prioritize them every year. We bring tribal members in, they prioritize the health care delivery system. You've given us the flexibility to work within the funding level that we have to make that system delivery possible for them.

Mr. FALEOMAVAEGA. And the funding level has not been at all sufficient to meet those needs?

Mr. WILLIAMS. No. I call it a "crisis care delivery system." When somebody can't afford to go to see a provider until they are so sick that they have to go to the hospital, and they can't go for prenatal

visits, that's a crisis care system. We want to transfer that to a prevention system.

Mr. FALEOMAVEAGA. Thank you, Mr. Chairman.

Mr. HAYWORTH. Thank you, Mr. Faleomavaega. The gentleman from Washington State.

Mr. INSLEE. I'd ask consent to place a statement, if I may?

Mr. HAYWORTH. Without objection, it's so ordered.

[The prepared statement of Mr. Inslee follows.]

STATEMENT OF HON. JAY INSLEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. Chairman, I am glad that we have the opportunity to learn more about the critical and sometimes complicated issues surrounding contract support costs for Indian programs. I look forward to hearing from and working with my colleagues on the Committee and today's witnesses, especially NCAI Chairman Ron Allen, who is chairman of the Jamestown S'Klallam Tribe in Washington. For those of my colleagues who may not know this, I am privileged to have the Jamestown S'Klallams located in my Congressional District.

The Indian Self-Determination and Education Assistance Act gives tribal governments the rights to assume local control over Federal Indian programs, such as health care, law enforcement, education, and natural resources management. A major principle of the Federal Government's policy under Self-Determination is that tribal governments should not be penalized financially for exercising their right under the law to operate their own programs.

Yet, that is the situation we find ourselves in today. Because Congress has failed to fully fund the costs associated with contracting, tribal governments are increasingly forced to spend their program funds to offset their contract support costs, pay these costs from tribal funds, or cut critical administrative activities below the level needed for contract compliance. I am concerned that the effect of this shortfall is that we are taking funds from one needed program in order to pay the administrative costs of another.

In addition, I am concerned that the current moratorium on new and expanded contracts contained in the FY 1999 Omnibus Appropriations Act is a not-so-subtle backdoor approach to eliminating the rights of tribes to operate their own local programs under the Self-Determination Act. We should not let appropriations riders take away Indian self-determination or undermine tribal sovereignty.

I would like to commend the Chairman for holding this hearing today. I look forward to working with tribal governments, the Administration and my colleagues to find a solution to this issue so that tribal governments will be able to fully exercise their self-determination rights under Federal law.

Mr. INSLEE. I do have a couple of questions, if I may?

Mr. HAYWORTH. Certainly.

Mr. INSLEE. First, I want to thank you all for coming, particularly Mr. Chair for journeying from the serene bay where you hang your hat all the way to try to horsewhip Congress into doing the right thing. That takes a lot of energy and we appreciate that.

But I'd like to ask you why do you perceive, and this is an issue that folks who believe in devolution, folks who believe in having local governments handle affairs, folks who believe we ought to devolve power to the governments who are closest to the people, also at times some of those folks seem to be the ones most opposed to fully funding self determination.

Why is that? I mean, what possible reason do you think we are up against in trying to convince them to fulfill this obligation to the Native American Nations?

Mr. ALLEN. Congressman, it's a complicated question you ask. And I guess one of my simple answers is that I believe that there is a subliminal philosophy that permeates throughout our society with regard to Indian affairs, who the Indian people are, what our governments are all about. And I believe that as you move the Fed-

eral policy of empowering tribal government forward there is not really a belief that tribal governments were going to be really fully empowered, tribal governments.

And over the course of the last 25 years tribes have proven that they can be very effective in every aspect of governmental operation. And all of the sudden you end up with a new level of clashes over jurisdiction and control, over controlling affairs over our communities whether it's in rural settings or it's in urban settings. And, unfortunately, there is this notion that there is no obligation to the Indian people into perpetuity for the relinquishing of the lands and the resources that our peoples gave up. That is simply a premise that is unacceptable. It isn't honoring the commitment of the United States to these peoples and our governments.

Now, as tribal governments continue to grow there is a notion, and it hides behind different theories, about how to be accountable for the Federal resources designated to serve our communities. It is increasing but it is not increasing proportionately.

But we're going to show you and the rest of the Congressional leadership, in our education campaign, that when you look across every Indian program, we are categorically not maintaining the same pace as the other programs serving mainstream America. And even though there is increases, proportionately we are not increasing and keeping pace with mainstream America.

How are we expected to be self sufficient, how are we expected to become independent governments within the Federal system, and how are we going to serve our people? We cannot, if we're not provided the same respect as other governments.

Mr. INSLEE. Well, I appreciate your passion. You know, sometimes I encourage witnesses to be dispassionate, but in this case I welcome it. And I'm glad you are here showing it because I think it's appropriate. Let me ask, and anyone on the panel can help me. Is there a current litigation? One of the previous panelists made reference to a court case of some sort involving the BIA. If anybody could tell me the status of that, I'd appreciate it.

Mr. MILLER. Yes, Congressman, there are presently about a half dozen cases wending their way through different parts of the court system. Some of them are in the Interior Board of Contract Appeals, some of them are at the Appellate level of the Federal System, some are in the Federal District Courts.

Assistant Secretary Gover alluded to a judgment awarded against the Bureau of Indian Affairs on behalf of all tribes in the United States, a deal with the Bureau of Indian Affairs. The matter was concluded on liability, as settled, on damages at \$76 million. That sum is now being approved by the Federal District Court, and we understand a final approval is imminent any day this week.

Mr. INSLEE. And what is the basis? I mean how is that number adjudicated? Does that go to a certain time period or—

Mr. MILLER. Yes, it was a certain time period. Prior to 1994, between 1988 and FY 1993, for those fiscal years, the Bureau of Indian Affairs employed a method for determining contract support costs that actually diluted its responsibility. It counted in the calculation of contract support small programs from other Federal

agencies that don't contribute contract support but also don't contribute materially to the work load of the tribe.

But counting those programs, the Bureau of Indian Affairs was able to shave in a small way its own responsibility, where shaving it in a small way for 500 tribes for five years became quite a large sum. And the \$76 million represents a settlement on that amount.

The case is actually into a second phase now, being handled by a Mr. Michael Gross, out of Albuquerque, New Mexico, where they will be looking at the BIA policies from 1994 to the present.

Mr. INSLEE. Does the shortage which we've been addressing here, is that potentially subject to further litigation? Can the judicial system solve this problem potentially, if Congress does not?

Mr. MILLER. Well, I think the judicial system has been called upon by individual tribes and even on a larger basis to do exactly that, Mr. Congressman. It would be unfortunate, however, I think for the policy of the United States, if it was the judiciary that had to call the United States Congress and—

Mr. INSLEE. I'm not suggesting that.

Mr. MILLER. [continuing] into account for such an important responsibility. But I think if Congress is unable, working with the agencies, with the Indian tribes, to find some common ground in this area, the courts are going to continue issuing rulings against both agencies that will be extremely costly.

Mr. INSLEE. Thank you.

Mr. ALLEN. Mr. Chairman, might I add just a little bit to that?

Mr. HAYWORTH. Certainly.

Mr. ALLEN. In our report to you and the Senate, we're going to address this issue and its complications. And we're going to throw out some suggestions about how to address this very complicated issue that was raised in the court. It causes a lot of people a lot of concern. And we believe there is a very constructive solution that can be proposed to the Congress in terms of how to address it.

Mr. HAYWORTH. Thank you. The gentleman's time has expired. The Chair would reiterate that if any member of the Committee has questions for either the first or the second panel, if they would submit questions in writing to the Committee staff. Mr. Faleomavaega made the point earlier and we're very happy to follow up with those inquiries.

I would also state for the record that questions in writing will be submitted from the Pascal Yaqui Tribe of Arizona, some of my friends in my home state who also have some concerns. Is there any further business?

Mr. KILDEE. No. I just want to thank the Chairman and yourself for chairing this meeting today. I think it was very, very helpful. I think this is an area that is not just a legal area, it's a moral area. We have a legal and moral obligation to carry out those responsibilities and I think you presented the case very, very well. We have to pursue this until you secure full justice.

Mr. HAYWORTH. The gentleman from American Samoa?

Mr. FALEOMAVAEGA. Mr. Chairman, the 11 years that I have been a member of this Committee, I, too, would like to echo the sentiments that have been expressed earlier in terms of your leadership and the dynamic services that you have provided for the In-

dian Country. And I really would like to commend you for your dedication to this.

Because so often and so many times whenever Indian issues are brought before this Committee and the Congress—it's not because I question the sincerity or the insincerity of those members—that affect the needs of our Native American community, somehow things just don't get done.

And Mr. Chairman, I want to thank you for your personal attention given to this real serious problem that we have in our Nation. And I do want to say that for the record. Thank you.

Mr. HAYWORTH. I thank you Mr. Faleomavaega. It's good to have my friend from American Samoa, who during the course of the 104th Congress, on a very aforementioned August day, foreswore his tropical paradise to come to the desert—

Mr. FALEOMAVAEGA. Mr. Chairman, as long as you'll continue this leadership, I promise I will export more football players to the University of Arizona and Arizona State.

Mr. HAYWORTH. And let me state for the record, even though Arizona is my home, at North Carolina State University, I enjoyed the services of Ricky Logo, from Samoa for many years, and we appreciated that. And he had to return home to become King, so he was certainly well prepared with his education at North Carolina State.

Mr. FALEOMAVAEGA. If the Chairman will yield. Most of my cousins have played for Arizona State and the University of Arizona, and they continue to do so. And I'm going to tell them to do so as long as my friend J.D. helps my Native American brothers and sisters. Thank you.

Mr. HAYWORTH. I thank you, Mr. Faleomavaega. And again I thank you not only for your kind comments but all the witnesses for their valuable testimony. And if there is no further business, again we thank the members and the members of our panel. And the Committee stands adjourned.

[Whereupon, at 12:45 p.m., the Committee was adjourned.]

STATEMENT OF HON. JOHN M. SPRATT, JR., A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF SOUTH CAROLINA

Dear Chairman Young,

Thank you for allowing me the opportunity to submit testimony regarding the difficulties encountered by the Catawba Indian Tribe of South Carolina in obtaining adequate Indian Health Services and contract support funding. The Catawbas' relationship with the Federal Government was terminated in the early 1960's and was not re-established until Congress passed legislation to do so in the mid-1990's. Prior to recognition, the tribe did not keep an up-to-date, accurate, or complete record of its members. The tribal roll the Catawbas relied upon when originally filing for IHS funding understated its tribal membership by over one-half.

The Catawbas first sought IHS funding in fiscal year 1994 directly following their land settlement and Federal recognition. At that time the Catawbas had no paid staff. A loose roll of 1,200 members was kept as a courtesy by an elderly member, now deceased. Although this roll did not reflect an accurate accounting of members' deaths, births, and marriages, it was used by the Catawbas because it was the only list of members available when the tribe filed for IHS funding. The tribe has since found that they have a health service population of 2,700, over twice as many as originally reported.

The Catawbas are currently funded at \$1.5 million, or \$779 per person, which is well below the average Indian Health Services funding of \$1,430 per member. The tribe spends \$2.5 million a year on health care, or \$1 million more than IHS funds. As a result, they must scrape together this additional money from other programs in an already tight budget.

Other Native American tribes with similar populations are funded at twice the level of the Catawbas. The Yuma Indians, for example, receive \$4.1 million a year for a near identical service population. The Catawbas deserve the same level of funding received by other similarly situated tribes, and should at least get funding commensurate with the current determination of their membership.

In addition, the Catawbas have consistently been denied proper payment for IHS contract support costs. Since their Federal recognition in 1993, the tribe has been underfunded by \$1.8 million in contract support costs on their contract. In FY97, for example, the Catawbas' contract support rate was set at 51.1 percent or \$414,368, of which they received only \$57,000. Without the proper funding, the tribe has both downsized their health-related services and taken steps to cede the administration of their health program back to Indian Health Services. The Catawbas simply cannot afford to maintain it without the proper funding.

Thank you for holding a hearing on this important matter. I would very much appreciate having this letter entered in the record of the hearing.

STATEMENT OF MICHAEL E. LINCOLN, DEPUTY DIRECTOR, OFFICE OF THE DIRECTOR,
INDIAN HEALTH SERVICE

Good morning. I am Michel Lincoln, Deputy Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Douglas Black, Director, Office of Tribal Programs; and Ms. Paula Williams, Director, Office of Tribal Self-Governance. We welcome the opportunity to testify on the issue of contract support costs in the Indian Health Service. Contract support cost funding is critical to the provision of quality health care by Indian tribal governments and other tribal organizations contracting and compacting under the Indian Self-Determination and Education Assistance Act (ISDEA), Public Law (P.L.) 93-638).

The IHS has been contracting with Tribes and Tribal organizations under the Act since its enactment in 1975. We believe the IHS has implemented the Act in a manner consistent with Congressional intent when it passed this cornerstone authority that re-affirms and upholds the government-to-government relationship between Indian tribes and the United States.

At present, the share of the IHS budget allocated to tribally operated programs is in excess of 40 percent. Over \$1 billion annually is now being transferred through self-determination agreements to tribes and tribal organizations. Contract support cost funding represents less than 20 percent of this amount. The assumption of programs by tribes has been accompanied by significant downsizing at the IHS headquarters and Area Offices and the transfer of these resources to tribes.

Contract support costs are defined under the Act as an amount for the reasonable costs for those activities that must be conducted by a tribal contractor to ensure compliance with the terms of the contract and prudent management. They include costs that either the Secretary never incurred in her direct operation of the program or are normally provided by the Secretary in support of the program from resources

other than those under contract. It is important to understand that, by definition, funding for contract support costs is not already included in the program amounts contracted by tribes. The Act directs that funding for contract support costs be *added* to the contracted program to provide for administrative and related functions necessary to support the operation of the health program under contract.

The requirement for contract support costs has grown significantly since 1995 due to the increasing assumption of IHS programs. In the fiscal years 1996 and 1997 appropriations committee reports, the IHS was directed to report on Contract Support Cost Funding in Indian Self-Determination Contracts and Compacts. In the development of this report, IHS consulted with tribal governments, the Bureau of Indian Affairs (BIA) and the Office of Inspector General within the Department of the Interior. The report detailed the accelerated assumption of IHS programs by tribes beginning in 1995 as a result of the 1994 amendments to the ISDEA and authorization of the Self-Governance Demonstration Project for the IHS. The report showed that despite the significant growth in self-determination contracting and compacting, contract support cost appropriations have remained relatively flat. This has resulted in under-funding of contract support costs. The report also highlights that the rates for tribal indirect costs, which are the major component of contract support costs, have averaged around 23 percent of direct program costs over this same period of time.

In addition, pursuant to the statutory requirements of the ISDEA, the IHS gathers contract support cost data annually as a part of its annual "Contract Support Cost Shortfall Report To Congress." This report details, among other things, the total contract support cost requirement of tribes contracting and compacting under the ISDEA and how these funds are allocated among the tribes.

As a result of the increase in contract support cost appropriations in FY 1999, the IHS will be able to fund, on average, approximately 80 percent of the total contract support cost need associated with IHS contracts and compacts. No tribe will be funded at less than 70 percent of their overall contract support cost need. Although the IHS projects future need for contract support costs on an annual basis, there are many variables associated with these projections that are outside the control of the IHS. These variables include: the fact that self-determination is voluntary and solely at the initiative of tribes and that indirect cost rates can fluctuate. The contract support costs shortfall at the beginning of fiscal year 1999 was approximately \$52 million.

The IHS adopted a contract support cost policy in 1992 in an attempt to address many of the issues surrounding the determination of tribal contract support cost needs authorized under the Act and the allocation of contract support cost appropriations from the Congress. This policy was subsequently revised in response to the 1994 amendments to the Indian Self-Determination Act. In response to concerns expressed by the Congress, the IHS is currently working on a third version of the policy. We will work with Congress, the tribes, and BIA to develop contract support costs solutions that are more in line with the budget cycle, in order to better predict future CSC needs. In concert with Departmental and IHS tribal consultation policies, the IHS is working closely with tribal representatives in the development of this revised policy.

Before any agency policy on contract support costs is adopted, tribal leadership is consulted and the significant procedures under consideration are discussed in great detail. While we do not always arrive at the same conclusion as tribal leadership, the process is mutually beneficial and has always resulted in a more harmonious relationship. We first engaged tribes with the need to modify the IHS contract support cost policy last fall.

Since then, we have met with tribal technicians and administrators on three occasions. We are continuing the process and will be meeting again in early March. We anticipate having a final draft of the policy available for tribal leaders to review and comment on in late spring. The policy should be finalized by mid-summer for implementation in advance of FY 2000.

In addition to the specific IHS contract support cost policy work, the IHS and the Bureau of Indian Affairs have also collaborated with the National Congress of American Indians (NCAI) on the contract support cost study they have undertaken. It is my understanding that the NCAI will forward an interim report on contract support costs to the Congress in the near future. In addition to the NCAI study, the IHS is presently providing data and information to the General Accounting Office (GAO) to assist that organization in its ongoing review of contract support costs. As you know, the Congress has directed the GAO to undertake a comprehensive study of contract support costs in the IHS and BIA. We look forward to the results and findings of that study, which will be delivered to the Congress in June.

Thank you for this opportunity to discuss contract support costs in the IHS. We look forward to working with the Congress in addressing this important issue. We are pleased to answer any questions that you may have.

STATEMENT OF W. RON ALLEN, PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

I. INTRODUCTION

Good morning Mr. Chairman. My name is W. Ron Allen and I am the President of the National Congress of American Indians (NCAI) and the Chairman of the Jamestown S'Klallam Tribe of Washington State. NCAI is the largest and oldest membership organization of Indian tribes in the United States, and advocates on behalf of all the Nation's 558 federally recognized Tribes. I am honored by the Committee's invitation to appear and testify on the Indian Self-Determination Act and the role that contract support costs has played under that Act.

II. INDIAN SELF-DETERMINATION ACT OF 1975

The Indian Self-Determination Act of 1975 has proven to be the cornerstone of the Nation's modern policy toward empowering tribal governments. The Act rejected all of the Nation's past failed policies toward our tribes, including paternalism, forced dependency, assimilation and outright termination of our unique status as governments. In their place, it established the basic framework for tribal self-determination, tribal economic recovery, transfer of Federal resources and services to tribal operations and true government-to-government relations between tribes and the United States.

The Act has directly led to every major American Indian and Alaska Native initiative to come before this Congress in the last quarter century, and the self-determination goal has become a reality for hundreds of tribal communities seeking greater autonomy, responsibility, accountability and control over their daily affairs and their destiny. Thanks in major part to this Committee's continuing and unbroken vigilance to protect against any erosion of the Act, either administratively or through legislation, the Self-Determination Act has proven a resounding success in lifting up our tribal communities, elevating the health status of Native American peoples by improving the quality and expanding the delivery of our health care services, promoting local innovation, relieving unemployment, improving educational opportunities, improving tribal justice systems and law enforcement, and removing the distant Federal Government bureaucrats from our daily affairs.

Even with these improvements, however, the continuation of serious problems still exist. As a 1987 Senate report stated, in the course of strengthening the Act, "perhaps the single most serious problem with implementation of the Indian self-determination policy has been the failure of the Bureau of Indian Affairs and the Indian Health Service to provide funding for the indirect costs associated with self-determination contracts."

III. CONTRACT SUPPORT COST UNDERFUNDING

The Senate Indian Affairs Committee, and this Committee, noted that the failure to fully fund indirect costs had resulted in severe difficulties for tribes who incur enormous costs not borne by IHS and the BIA, and who must also carry out functions similar to those carried out by a variety of other Federal agencies that support the BIA and IHS, but which are beyond the reach of the Act. For many tribes, the IHS and BIA practice of underfunding contract support costs meant either compromising on these essential functions, reducing already underfunded program services to help cover these requirements, or both.

In 1988 and in 1994, this Committee helped enact legislative amendments, among other purposes, intended to "prohibit" the underfunding practice, thus overcoming the funding problems and disturbing consequences. In some respects, the amendments worked and some of the contract support problems improved. But while tribes went on administering hundreds of Federal Indian programs, the agencies continued to defy the statutory and contractual mandates to fully fund contract support costs.

With respect to both the BIA and the IHS, the administration refused to use all available funds to meet their obligations and failed to ask for sufficient additional funding from Congress to get around their self-imposed limitations. Unfortunately, the Administration eventually supported statutory funding "caps" designed to protect the agencies from ever fully paying the tribes the amounts determined to be necessary by the agencies.

On the BIA side, an additional BIA policy (known as the pro rata policy) has long meant that today tribes never know until a fiscal year is almost over, and their pro-

grams are almost fully carried out, how much they will receive in contract support costs that year. From year to year, the payment jumps up and down anywhere from the mid 70 percent to the low 90 percent range. Unfortunately, over the last 6 years, the payment schedule has averaged in the low 80 percent range. This continuing practice seriously undermines the ability of tribes to achieve real financial stability and predictability even in one year, no less over the longer term.

To make matters worse, the BIA system fails to provide tribes with the same personnel benefits that the BIA's own employees receive when they carry out the same programs, making it that much harder to maintain service levels in tribal communities. From IHS's experience, we estimate that this failure actually pushes the BIA payments down in real terms another 20 percent below real need.

On the IHS side, IHS policies have until very recently led to a situation where years go by during which some (and occasionally all) of a tribe's health care programs receive no contract support costs at all. Although the IHS policy does offer tribes better predictability from year to year, most are nonetheless forced to operate with substantial contract support deficits.

IV. NCAI NATIONAL POLICY WORK GROUP ON CONTRACT SUPPORT COSTS

Faced with a growing crisis, last year (1998) NCAI established a National Policy Work Group on Contract Support Costs. Among the many goals of this initiative were: (1) to work aggressively with the agencies to improve the contract support situation; (2) to begin a serious educational campaign here in Congress on the need for contract support costs and on the impact of the current crisis on tribal service delivery; (3) to work more closely with the two Departments and the Office of Management and Budget to increase awareness of this critical issue; and, (4) to thoroughly explore all aspects of the contract support system and develop options and recommendations where improvements can be made for the benefit of all concerned.

Our intense work on this initiative has already contributed to achieving real progress on many fronts:

First, and thanks in major part to the bipartisan leadership and sensitivity of Appropriations Subcommittee Chairman Regula, Chairman Young and Congressman Miller, Co-Chairs Hayworth and Kildee of the House Native American Caucus, the House Leadership, as well as the support of Senator Ted Stevens, this year's appropriation included a 21 percent increase in contract support cost funding. Although IHS reports that funding will still be some \$90 million short in FY 2000, this year's increase has permitted very real correct corrections—and changes—to be made to a system in crisis.

Second, both the BIA and the IHS are now working closely with NCAI and others to reexamine their contract support cost policies. As a direct result of these efforts, in 1999, IHS expects to move all tribes closer to the 100 percent necessary funding level that some tribes—but far too few—already enjoy, and in doing so to correct the most severe funding inequities that have plagued the IHS system. For IHS, this represents a major change from past contract support policies.

Third, IHS in particular has made enormous strides in improving the accuracy of its data, thanks to truly tremendous and concentrated efforts by the agency, and thanks also to a solid commitment to consult and work more closely with tribes.

Fourth, NCAI has issued two interim reports summarizing our work and much needed data on all aspects of the contract support cost system. The first report was distributed to all members of Congress, all relevant agencies, and all Indian tribes; and, the second report is just now under distribution. Copies of both reports have been attached to my written testimony today, and I think Members will find the information invaluable to a thorough understanding of the system. We anticipate having our final report out this spring.

Fifth and last, the Administration has now requested an additional 17 percent increase in contract support appropriations to IHS for FY 2000. This is the first time any Administration's budget request has ever acknowledged to such a degree the serious need in this area, and we hope the House and Senate will substantially build upon that request in the coming months. Although the President's budget reflects an increase to remedy the near-equally serious BIA shortfall, here too we hope to work closely with Congress and OMB to better address the need for FY 2000. Unfortunately, the BIA is projecting increased levels which will only fund 86 percent of need in FY 2000.

Our reports have also revealed important little known facts regarding the contract support system. For instance,

- Our research has clearly dispelled the notion that CSC costs are “out of control.” Individual tribal requirements for contract support costs have remained level over several years. In fact, they have not increased and are consistent with

other Federal agencies contract support cost-type reimbursements—even though the average rate of these inter-agency rates are almost double that of the average tribal indirect cost rates.

- The increased demand for contract support costs over the mid-1990s was directly caused by more tribes taking advantage of the Self-Determination Act's opportunity to operate the IHS and BIA programs.

- On average, contract support costs account for about one-quarter of a tribe's total IHS funding (when fully funded), and a smaller proportion of a tribe's total BIA funding. The difference partly reflects the fact that a number of BIA programs involve pass-through payments (such as general assistance and scholarships), and partly reflects the fact that the BIA still fails to recognize tribal direct contract support cost requirements.

- In every year since 1980 both the Federal agencies and Congress have known the extent to which contract support costs requirements have gone unfunded. And yet, and until this year, the amounts made available by Congress, the agencies or both have not come close to meeting the need, driving the IHS backlog higher and higher, and leaving the BIA system essentially stagnant.

- Over one-half of the IHS programs are operated by tribes, and a larger portion of the BIA programs operated by tribes, involve programs smaller than \$500,000, while only 7 percent exceed \$5 million.

- Tribal contract support cost requirements have varied due to diverse local circumstances. No "one size fits all" approach can be sensitive to this highly variable situation.

- The rate of growth in tribal contracting and compacting activities with IHS and BIA has slowed markedly, with each agency now projecting new contract support demands per year at approximately \$12.5 million and \$5 million, respectively.

- In a recent three-year period, IHS staffing-reduced by 6 percent, with substantial additional IHS staff currently detailed to tribal programs. In the last 17 years, BIA staffing has reduced by over one-third. (Relative to IHS, there are very few BIA staff currently detailed to tribal programs.)

V. CONCLUSION

Mr. Chairman, a large proportion of the Nation's tribes has taken advantage of the Self-Determination Act's opportunity to administer IHS and BIA programs. The result has been highly accredited and acclaimed health care programs, increased governmental and program service delivery through reductions in red-tape and bureaucracy, innovative partnerships with state agencies, multi-fold increases in third-party revenues from Medicare, Medicaid and private insurance, a broader array of program choice for tribal members, more relevant and locally-prioritized health and social service programs, and significant and measurable improvements in the communities' quality of life.

We have much to applaud in what tribes have done for themselves in the past 25 years, even with legislative and policy restrictions including inadequate funding to fully implement tribal self-determination and self-governance goals. The Congress and the Administration have been advancing the "devolution" process to empower state and local governments. This movement is based on a simple theory that the communities in our country will be better served when the Federal Government provides greater control and flexibility over Federal resources to address these community needs. This goal should be applied equally and consistently with the 558 tribal governments throughout the United States.

One important consideration that must be recognized by the Federal Government is that the tribes do not have the same revenue-generating base as state and local governmental tax authority system. In conjunction with this fact, the Congress must remember it has a historical, legal and moral obligation to the tribal governments in lieu of the vast lands and resources relinquished to the United States by the tribes.

We therefore respectfully caution the Committee to reject recommendations that would revamp the Self-Determination Act in significant ways, such as by deferring new contract starts, deferring tribal entitlements to receive contract support, or otherwise weakening the Act's contract support cost provisions. These options would severely undermine the tribes' governmental capacity to provide effective and responsible programs and services to their communities.

We do believe, however, that improvements can certainly be made in how the Act has been carried out. For instance, IHS and BIA can report to Congress on a more timely basis the contract support cost needs anticipated both for the current year and the upcoming new year. Further, we believe the agencies can do a better job

of refining and standardizing the process for determining contract support cost needs.

The contract support crisis is solvable—with refinement in the agencies' policies, the renewed commitment from Congress and the Administration shown this year, and the willingness of tribes to join in the search for innovations that will help further close the gap. Through the collaborative work of the NCAI Workgroup on Contract Support Costs, we are developing recommendations which support similar CSC approaches and policies within the BIA and IHS. While the Workgroup is exploring options regarding consistent standards and criteria in the calculation of all aspects of contract support costs (including start-up costs, direct contract support cost and indirect costs), these options recognize areas of commonality among tribes but are also sensitive to the unique differences among us.

NCAI stands ready to assist the Congress and Indian country to reach this goal, and we are hard at work as I speak doing our part to make it happen. Mr. Chairman, thank you once again for the opportunity to share these thoughts with the Committee.

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*NATIONAL CONGRESS OF AMERICAN INDIANS
NATIONAL POLICY WORKGROUP ON
CONTRACT SUPPORT COST*

FIRST INTERIM REPORT



September 1998

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In April 1998 the National Congress of American Indians (NCAI) hosted an open forum in Las Vegas for tribal leaders from throughout the United States and officials of the Bureau of Indian Affairs (BIA), U.S. Department of the Interior (DOI), and of the Indian Health Service (IHS), U.S. Department of Health and Human Services (DHHS). The attendees at the meeting included Assistant Secretary of Indian Affairs Kevin Gover, Deputy Director of the Indian Health Service Luana Reyes and NCAI President W. Ron Allen.

The purpose of this open forum was two-fold: first, to explore changes and reforms in the contract support cost system in light of recent developments in the federal courts and in the Interior Board of Contract Appeals (including such cases as *Shoshone-Bannock Tribes v. Shalala*, *Ramah Navajo School Board v. Babbitt*, *Ramah Navajo Chapter v. Babbitt*, and *Micosukee, et al. v. Bureau of Indian Affairs*); second, to explore more broadly the evolution of the contract support cost system within each Department over the past twenty years, and to explore possible reforms and other measures that could help close the funding shortfall presently experienced by all tribes involved in contracting or compacting under the Indian Self-Determination Act.

The Las Vegas open forum led to the formal establishment of the NCAI National Policy Workgroup on Contract Support Cost. In organizing the Workgroup, the Las Vegas participants determined to seek the participation not only of tribal governments, the BIA and IHS, but also representation from the DHHS Office of the Secretary and the DHHS Division of Cost Allocation (DCA), the DOI Assistant Secretary for Policy Management and Budget, the DOI Office of Inspector General (OIG), and the Office of Management and Budget (OMB).

In June 1998, a small tribal working group developed a first set of research requests for IHS, DHHS-DCA, BIA and DOI-OIG. The data and research requests were then confirmed in letters from NCAI President W. Ron Allen. On July 24, 1998 the full Workgroup convened in Washington, D.C. This **First Interim Report** summarizes some of the high points and key findings that have emerged thus far in the Workgroup deliberations. In setting forth these preliminary findings and highlights, readers are cautioned that research into a wide range of issues pertaining to contract support costs is ongoing. In some instances, data collected thus far is incomplete or requires additional analysis. For these reasons, the findings set forth below are tentative, only, and subject to change as additional research proceeds. They should not be interpreted as reflecting the final view of the Workgroup or of the participating members. However, the current data is useful in forming some initial conclusions and providing a basis for the Congress to delay action until both the General Accounting Office (GAO) and the Workgroup can complete their tasks.

In the weeks immediately preceding the July 24 Workgroup meeting, the

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House and Senate Appropriations Committees have simultaneously developed alternative approaches for addressing a variety of contract support cost issues. The more significant of these includes (1) a House-proposed \$26 million increase in CSC for the Indian Health Service, (2) a statutory directive proposed in the House and the Senate that the Indian Health Service prorate proportionately all contract support costs, (3) a moratorium proposed in the House on any additional contracting or self-governance compacting in Fiscal Year (FY) 1999 (section 329), and (4) a measure proposed by both the House and the Senate that seeks to retroactively limit BIA and IHS liability in prior years for payment of contract support costs (section 314).

As indicated below, in two instances (the House-proposed moratorium, and the House and Senate proposed IHS proration instruction), both federal (other than DOI-OIG which did not comment on the proposals) and many tribal Workgroup participants expressed strong opposition (provided substantial additional amounts are appropriated in FY 1999 and prorated over the queue). With respect to the proposed Section 314 retroactive limitation of liability requested by the Administration, Tribal Workgroup members voiced strong opposition and concern over both the questionable constitutionality and policy implications of such a measure.

The first set of interim findings and highlights of the Workgroup deliberations to date are organized to directly respond to some of the issues raised by CSC-related provisions proposed by the House and Senate Appropriations Committees for FY 1999 and are the following:

- With respect to the Indian Health Service, it is estimated that by the end of FY 1998 there will be a total contract support cost requirement of approximately \$300 million. If (as proposed by the Senate) CSC appropriations are capped at \$170 million, there will be a shortfall of an additional \$130 million. If (as proposed by the House) CSC appropriations are capped at \$194 million, there will be a shortfall of \$106 million.
- The CSC "shortfall" suffered by IHS contracting and self-governance tribes is a combination of (1) shortfalls in CSC funding for programs long ago transferred to tribal operation, and (2) shortfalls in CSC funding for more recently transferred programs that have to date not yet received any CSC support at all. (The recent House floor debate appears to have only considered the second type of shortfall, and only as of the beginning of FY 1998.)
- In general, the distribution of CSC among IHS tribal contractors and

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self-governance compactors has not produced a system of "haves" and "have nots." This is because the overwhelming majority of tribes whose programs are listed on the IHS "queue" list (the list which sets forth all recently transferred programs that are still awaiting receipt of CSC funding) also operate a substantial number of other programs that are receiving CSC funding because they were long ago transferred to tribal operation. No data is yet available regarding the "blended" shortfall being experienced by each tribe if contract support cost needs for ongoing programs are combined with the contract support cost needs for programs listed on the "queue."

- The IHS and the BIA have for many years used an identical system for funding contract support associated with newly transferred programs. In both agencies, newly transferred programs receive funding on a first-come/first-served basis from each agency's Indian Self-Determination Fund. In recent years, the BIA Indian Self-Determination Fund has been generally sufficient to cover all such needs, avoiding a large accumulated backlog. The IHS Indian self-determination fund has not been similarly sufficient to keep pace with new contracting and self-governance activities.
- The Indian Health Service and a majority of tribes oppose an immediate transition to an across-the-board pro rata system. Using the proposed Senate funding levels, such a system would fund total contract support cost needs at approximately 57 percent. Using the proposed House-funding levels, such a system would fund total contract support cost needs at approximately 64 percent. Such an across-the-board funding rule would cause substantial (and for some tribes, devastating) dislocations and impacts for programs that are currently funded at substantially greater percentages of need. Further, many tribes have constructed or acquired health care facilities and incurred fixed costs (debt service) in reliance on the CSC funding provisions of the Indian Self-Determination Act and the current IHS CSC distribution policy. At a time when the federal government is unable to address much needed facilities, an imposed pro-rata distribution would discourage tribes from developing their own alternative financing by disrupting stability of financing options.
- The Administration's decision not to request increased CSC funding in FY 1998 must be viewed against a backdrop of congressional rejection of prior Administration requests for substantial increases in contract

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support for IHS.

- Recognizing the considerable gap that has developed over the past four years between CSC needs for IHS contractors and self-governance tribes, and the level of funding distributed by IHS for such purposes (particularly for tribal programs listed on the IHS "queue"), the Workgroup supports as an interim measure substantially increased funding for FY 1999, in the neighborhood of \$50 million, with such sum to be distributed proportionately to all programs listed on the IHS "queue." This proposal would leave all other tribal programs at the FY 1997 - FY 1998 funding levels.
- The Workgroup supports the proposed Senate approach that rejects a moratorium on new program contracting activities in FY 1999.
- The tribal participants in the NCAI Workgroup strongly oppose the section 314 proposed retroactive extinguishment of IHS and BIA liability for contract damage claims. These Tribes urge Congress to relieve Tribes from years of litigation over the constitutionality of such a provision by deleting it from the final FY 1999 appropriation bill.
- IHS has received one tribal notification of an intent to "retrocede" its contracted programs back to IHS operation, in the event the tribe's contract support costs are prorated down as contemplated in currently pending appropriation bills. IHS is concerned that other tribes may similarly announce their intent to transfer contracted or compacted programs back to IHS. IHS is not prepared to take back direct operation of a substantial number of such programs.

The next set of findings or highlights are geared toward an historical review of self-determination and self-governance activities:

- The Indian Self-Determination Act provides for three types of contract support costs: (1) start-up and pre-award costs, (2) recurring direct contract support costs and (3) indirect costs.
- Start-up and pre-award costs are "start-up" costs as defined by Congress in 25 U.S.C. § 450j-1(a)(5). Direct contract support costs include insurance and other forms of fringe benefits on top of salary costs (such "fringe" benefit resources are generally not transferred from federal control to tribal control). Indirect costs pay for each program's

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proportionate share of the financial management and audit systems, personnel management and payroll systems, procurement systems, facility support activities, and other administrative activities that must be carried out by a tribal contractor. (In general, the comparable federal functions associated with indirect costs are not transferred to tribal control because they are situated either outside the particular agencies and elsewhere within the Departments, or are situated in other departments, such as the Office of Personnel Management, the General Services Administration, etc.)

- The IHS CSC system endeavors to pay all three forms of CSC specified in the Indian Self-Determination Act, and both the CSC need amounts and the CSC shortfall amounts are reflective of this policy. In contrast, the BIA CSC system only funds both start-up and indirect costs but has never direct contract support. The Workgroup will endeavor to determine the financial impact of the differences between the BIA system and the IHS system in these respects.
- The total contract support costs required by tribes to fully support IHS programs transferred to tribal operation has ranged between 31 percent and 36 percent of the total program costs. The ratio between total contract support costs required and the size of the IHS programs transferred to tribal operation appears to have remained steady over the past three fiscal years. Additional research regarding FY 1997 and FY 1998 is underway.
- Of the total contract support required by tribes in connection with IHS programs transferred to tribal operation, on average 79 percent of the contract support reflects indirect costs, and 21 percent reflects direct contract support. The ratio of these two types of contract support does not vary substantially regardless of the size of the IHS programs under tribal operation (looking at six break points from tribes operating fewer than \$500,000 in IHS programs to tribes operating more than \$20 million in IHS programs).
- Over one-half of the 396 tribally-operated IHS programs involve tribal health care programs totaling less than \$500,000. Another one-quarter involve programs ranging between \$1 million and \$5 million. Only 27 programs are in excess of \$5 million (of which only seven are in excess of \$20 million).

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- The total aggregate contract support costs required by tribes operating IHS programs does not appear to vary substantially according to the size of the contracted programs. For contracts under \$500,000 the average contract support amount is 35 percent of the total program funding, while the average for contracts in excess of \$10 million is 33 percent. (The average is 26 percent for tribal contracts in excess of \$20 million in IHS programs.) Further research is necessary to better understand the low and high range of 20 percent to 41 percent, since this range does not initially appear to be directly related to the size of the contracted programs.
- The rate of growth in the transfer of IHS programs to tribal operation is slowing. Earlier IHS forecasts that contract support costs associated with such program transfers would total \$15 million are now being adjusted down, and IHS expects a similar downward trend in FY 1999.
- The only "spikes" IHS anticipates in connection with future CSC needs would be associated with the transfer of certain programs presently under IHS operation to the Navajo Nation and the Cherokee Nation. Total program funding for IHS-operated programs for these two tribes is approximately \$300 million, leading IHS to forecast a potential contract support demand associated with these two programs of between \$60 million and \$75 million. The Cherokee Nation has not indicated any intent to take over all or portions of those programs presently under IHS operation. The Navajo Nation has indicated an interest in commencing operation of a portion of the IHS programs serving the Nation in FY 2000.
- IHS staffing has changed dramatically from FY 1994 through FY 1997. Overall, IHS staffing (expressed as full-time-equivalent employees, or FTEs) has declined six percent. Significantly, substantial FTEs have been transferred from IHS Headquarters to IHS Service Units, a trend that is partly responsible for a 30 percent reduction in Headquarters FTEs, and an offsetting increase in service unit staffing. FTE reductions over the past four years have in some instances been offset by the staffing of new clinics and hospitals, including the Alaska Native Medical Center. IHS is continuing to assess the degree to which FTE reductions have occurred as a result of contracting or self-governance compacting activities.

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- Forty percent of the IHS budget is being administered by tribes. Total program funding for these transferred programs is approximately \$765 million.
- CSC funding covers a variety of fixed costs related to the administration of programs and facilities, and certain personnel expenses. To the extent CSC is insufficiently funded, a contracting or self-governance tribe may be forced to divert health care and social service funding and to reduce services, since for many contractors, especially smaller contractors, the cost of functions paid for by contract support are stable and cannot be prudently reduced (i.e., a bookkeeper, for example).
- The underfunding of contract support has in recent years caused at least two tribes to announce to IHS that they will suspend plans to contract for the operation of IHS programs. The IHS thinks that it is significant that only a few tribes have opted not to contract in the face of the ISD queue backlog and CSC shortfall.
- Observations, conclusions and judgments regarding indirect cost rates are treacherous, because the indirect cost rate system is exceedingly complex. Moreover, the flexibility built into the system for negotiating indirect costs can lead to tribal-specific indirect cost rate agreements that cannot be compared on an "apples-to-apples" basis, where a similarly-situated neighboring tribe has negotiated a different type of agreement using a different type of accounting and cost recovery system.
- According to Office of Management and Budget Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, indirect cost rates are computed by dividing the indirect cost pool by a direct cost base (normally either total direct salaries and wages or total direct costs). However, the total direct costs must be adjusted to eliminate any extraordinary or distorting expenditures such as subcontracted construction. As most tribes negotiate an indirect-cost rate against a "direct cost" base, the "direct cost" base is typically smaller than the total program base that is transferred to tribal operation. Accordingly, generally speaking indirect costs as a percentage of the "direct cost" base are an even smaller percentage of the total transferred program.
- For indirect cost rates covering FY 1997, the average indirect rate for tribes that negotiate indirect costs based on a "direct cost" base (which

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is the method used by most, but not all, tribes) goes down as the total size of the program increases. For example, tribes whose direct-cost base is under \$500,000 have an average indirect rate of 49.5 percent, whereas tribes with a direct-cost base in excess of \$20 million have an indirect cost rate of 22.7 percent. The single largest category of tribes, those with a direct-cost base of between \$1 million and \$5 million have an average rate of 31 percent. In each instance, however, the average rate represents an average of a large range of rates.

- There has been little overall variation in the average indirect cost rate negotiated for all tribes during the period 1988 through 1997. In most of these years, the average rate was between 32.1 percent and 35.6 percent.
- Each year a small number of tribes negotiates its indirect cost rate based not on its total "direct costs" but instead based only on "direct labor" costs. Given the much smaller base used in such calculations, the indirect rate for such tribes is necessarily higher than would be the case if the rate were negotiated based on total direct costs. The indirect rate for such tribes can be between 15 percent to 25 percent higher than the indirect rate that would be determined under a "direct cost" methodology. This does not necessarily mean, however, that the tribe receives any more total funding than it would were it using a different methodology for determining its indirect rate because the indirect cost rates are applied to the appropriate bases to determine the contract support requirement.
- The BIA has experienced a substantial reduction in FTEs during the period 1981 to the present (estimated), from a high of 16,868 FTEs to an estimated FY 1999 level of 10,251 FTEs. Additional analysis is necessary to permit an assessment of the extent to which FTEs have been reduced as a result of self-determination contracting or self-governance compacting activities.
- The Office of Inspector General computed, for the rates it negotiates with tribal organizations, that the average indirect cost rate for the period from 1987 through 1997 is approximately 25 percent. The OIG computed the overall average rate by dividing the total indirect cost pools by the total direct cost bases. This results in a different average than the averages discussed on Page 8, which were computed by dividing the sum of all rates by the total number of rates.

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- The BIA reports that, according to "A Guide for Nonprofit Organizations", the following agencies have indirect cost rates in excess of 50 percent: the U.S. Information Agency, the Department of Health and Human Services, the Department of Agriculture, state service delivery agencies, private foundations and fundraising organizations.
- Similarly, the BIA reports that during the period 1991 through 1995, 105 universities examined had an average indirect rate of between 52 percent and 53.1 percent.

The NCAI National Policy Workgroup on Contract Support Cost has scheduled its next meeting for September 18, 1998, again in Washington, D.C. At that time, the Workgroup will be receiving additional research, data requests and analyses requested from the Department of the Interior and the Department of Health and Human Services.

IHS reports that the DHHS Division of Cost Allocation (DHHS-DCA) has thus far declined to provide assistance to the NCAI Workgroup. The DHHS-DCA is the office within the Department that is responsible for negotiating indirect cost rates with tribes and tribal organizations whose cognizant agency is DHHS. In this sense, it is the counterpart to the Office of Inspector General of the Department of the Interior. A significant number of tribes, although not a majority, negotiate their indirect rates through the Division of Cost Allocation. Since many contractors, whose primary source of funding is the Indian Health Service, negotiate indirect cost rates with DHSS-DCA, it is essential to have input from and the cooperation of that agency in arriving at an improved mechanism for determining contract support costs which may be applied to IHS as well as BIA. Nor has the Workgroup received DHHS-DCA data regarding rate computations and trend analysis. The DHHS-DCA lack of participation may severely impede the work of the Workgroup. NCAI President W. Ron Allen has been requested to call upon Secretary Shalala and the relevant committees in Congress to urge participation by DHHS-DCA in the work of the Workgroup.

The Workgroup wishes to greatly acknowledge participation by a representative of the GAO. Based upon the instruction of the Senate Appropriations Committee in connection with the FY 1999 appropriation, GAO plans to undertake a study of contract support cost issues. The GAO representative reported that GAO planned to coordinate its activities with those of the Workgroup, so that the GAO would receive the benefit of all the research and analysis being undertaken by the Workgroup and might be able to share the results of its research with the Workgroup.

The NCAI Workgroup meeting of July 24, 1998 was not attended by any representative from the Office of Management and Budget (OMB), nor any representative

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from the DHHS Office of the Secretary or the DOI Office of the Assistant Secretary for Policy Management and Budget. The Workgroup hopes that representatives from these important agencies will participate in the Workgroup, and NCAI President W. Ron Allen will be sending new requests to these agencies urging their participation.

The NCAI National Policy Workgroup on Contract Support Cost appreciates that Congress will be looking both to the GAO and to the Workgroup for guidance and recommendations for improving the contract support cost system—a system upon which the Self-Determination Policy vitally depends. The NCAI Workgroup is fully committed to meeting this objective in a timely manner, and within the same schedule being chartered by the GAO. With the exception of increasing current funding, the NCAI Workgroup respectfully urges Congress not to make any substantial changes to any aspect of the contract support cost system pending the completion of the work of the Workgroup and of the GAO. Regardless of the reforms that may ultimately be made to the contract support cost system, it is clear that increased appropriations to IHS for contract support are essential to sustain the policy of self-determination. Congress is respectfully urged to use FY 1999 as an opportunity to substantially close the gap in the current CSC shortfall.

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***NATIONAL CONGRESS OF AMERICAN INDIANS
NATIONAL POLICY WORKGROUP ON
CONTRACT SUPPORT COSTS***

SECOND INTERIM REPORT



February 1, 1999

INTRODUCTION

Since the inception of the Indian Self-Determination Act of 1975, the Administration and the Congress have each failed to meet their legal obligations to fully fund tribal contract support cost needs associated with tribally-operated Bureau of Indian Affairs and Indian Health Service programs. The result, as frequently documented, has been to penalize tribes by forcing reductions in direct program operations, in order to support the administrative overhead associated with those programs. In essence, contracting tribes (and, more recently, self-governance tribes) have been punished for exercising their Self-Determination rights, as they have been compelled to reduce essential governmental programs in order to compensate for these failures.

The crisis in the Nation's Tribal Self-Determination Policy created by the consistent failure to fully fund contract support costs has been the subject of considerable congressional attention. In comprehensively revamping the Indian Self-Determination Act in 1988 – primarily to remedy this problem – Congress observed that the failure to fully fund contract support costs constituted the single greatest impediment to the success of the Tribal Self-Determination Policy. But despite the 1988 reforms, and a second round of comprehensive congressional reforms in 1994, the Administration and the Congress have to this day continued to force upon Tribes the duty to reduce direct program services in order to cover the failure to fully fund contract support. By 1998, it was estimated that the combined BIA and IHS contract support shortfall resulting from this failure exceeded \$200 million, and courts began to award Tribes damages against the agencies.

It is in this environment that in May 1998, the National Congress of American Indians formed the National Policy Workgroup on Contract Support Costs. The goals of the Workgroup were to explore the evolution of the contract support cost system within the Department of the Interior and the Department of Health and Human Services, to identify the problems that had developed in the system since the enactment of the Indian Self-Determination Act, to review recent judicial and administrative developments pertaining to contract support costs, and to explore possible changes and reforms in the funding and administration of contract support costs.

Following an initial phase of exploratory meetings, the Workgroup on September 1, 1998 issued a FIRST INTERIM REPORT. The FIRST INTERIM REPORT was developed at a time when Congress was revisiting issues pertaining to contract support costs through the appropriations process. Among other things, the FIRST INTERIM REPORT summarized available data relevant to the several proposals then under consideration by Congress. The REPORT also explained various aspects of the contract support cost system as implemented by the Bureau of Indian Affairs and the Indian Health Service over the years. With respect to the IHS system, the REPORT summarized Tribal and IHS opposition to a proposed immediate shift to a flat "pro rata" approach as 'robbing from the poor to pay the poorer,' and instead championed a substantial increase to begin addressing the shortfall.

More generally, the REPORT detailed at considerable length how the contract support cost system works; the trends in contract support cost ratios and related indirect cost rates; the rate of growth in self-determination and self-governance activities; the extent to which IHS and the BIA have been reduced as a consequence of self-determination and self-governance activities; relative indirect cost rates for government organizations, tribal foundations and universities; and other detailed information pertaining to contract support costs. The reader is urged to review these preliminary findings in considering this SECOND INTERIM REPORT.

The NCAI National Policy Workgroup on Contract Support Costs has now convened seven national meetings and several additional smaller committee meetings, including a special technical workgroup created to explore alternatives in the determination of tribal contract support cost needs. In the meantime, Congress has taken important new steps to address contract support cost issues as part of the FY 1999 appropriations cycle. This SECOND INTERIM REPORT is intended to summarize for the reader the developments which have occurred since September 1998, and to report on the progress of the NCAI Workgroup since that time. As of this writing (February 1999) the Workgroup anticipates completing its work by April 1999 with the issuance of a FINAL REPORT.

Admittedly, this schedule is ambitious given the complexity of the contract support cost system, the vital need to continue consulting with Indian country, and the need to thoroughly study the implications of any changes to the CSC system prior to their implementation. Within these constraints, the Workgroup intends to adhere to this schedule so that Congress has the benefit of this effort in deliberating over contract support cost issues in the course of the FY 2000 appropriations cycle, and in related oversight hearings to be convened by the House Resources Committee and the Senate Indian Affairs Committee.

REVIEW OF RECENT CSC-RELATED LEGISLATION

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1998 contained several provisions relevant to contract support costs.

First, for the Indian Health Service Congress appropriated \$203,781,000 as a special earmark, representing an unprecedented \$35 million increase over the amount appropriated for contract support costs in the preceding year.

Second, for the Bureau of Indian Affairs Congress appropriated \$114,871,000 in a special earmark for contract support costs, an increase of \$4 million over the prior year.

Third, Congress imposed an unprecedented one-year moratorium on any further transfers of BIA or IHS functions to tribal operation, under either the self-determination laws or the self-governance laws (section 328).

Fourth, Congress eliminated funding for each of the BIA's and IHS's so-called "ISD Funds," special accounts which in years passed had been used to fully fund the first year of contract support costs associated with a limited number of new contracts and compacts.

Fifth, Congress included identical provisions in the IHS and BIA portions of the Appropriations Act stating that contract support costs "may be expended only for costs directly attributable to contracts, grants and compacts pursuant to the Indian Self-Determination Act" and stating that such funds are not available "for any contract support costs or indirect costs associated with any [contract, compact or funding agreement] entered into between an Indian Tribe or tribal organization and any entity other than [the Indian Health Service or the Bureau of Indian Affairs]." See, e.g., section 114 (BIA).

Sixth, Congress included a measure (section 314) stating that "amounts appropriated to or earmarked in committee reports for the Bureau of Indian Affairs and the Indian Health Service" by the Appropriations Acts for FYs 1994 through 1998 for contract support costs "are the total amounts available" for those years for such purposes. The measure also makes an exception for the BIA, stating that "tribes and tribal organizations may use their tribal priority allocations for unmet indirect costs of ongoing contracts, grants, self-governance compacts or annual funding agreements."

Finally, Congress deleted a controversial proposal from the House and Senate appropriations bills which would have required IHS to reallocate all of its contract support costs on an equal pro-rata basis among all tribes and tribal organizations, rather than the historic basis used to date. Nonetheless, the conference committee expressed its view that IHS's "current distribution methodology . . . is inequitable and fiscally unsound." The conference committee directed IHS to work with Tribes "to remedy this inequity in the fiscal year 2000 budget request," but cautioned against any demand for "a large infusion of additional funding for contract support costs at the expense of either critical health programs or critical construction needs." The committee also noted that the temporary one-year moratorium "cannot be extended indefinitely."

BIA CONTRACT SUPPORT COST-RELATED ACTIONS IN FY 1999

Initially, the BIA considered not funding contracts and self-governance agreements which had been executed prior to enactment of the FY 1999 Appropriations Act, due to the section 328 moratorium. In light of the moratorium, the Bureau also considered not entering into any new funding agreements, even those that were revenue neutral with respect to contract support costs (such as conversions from self-determination contracts to self-governance compacts). And, agencies within the Department of the Interior other than the BIA (which likewise have contracting and self-governance obligations to Tribes), were initially viewing the moratorium to prohibit those agencies from entering into

new funding agreements with Tribes, notwithstanding that such other agencies' contract support cost needs are not funded through the contract support earmark described here.

Following consultation with the House and Senate Appropriations staff, the Bureau abandoned these interpretations. Accordingly, the BIA is now proceeding in a manner identical to the Indian Health Service: honoring all funding agreements executed prior to the enactment of the appropriations act, and executing new funding agreements that are revenue neutral. The non-BIA agencies are also entering into funding agreements to the extent authorized under the self-determination and self-governance laws.

As in the past, in FY 1999 the BIA will not be paying Tribes any direct contract support costs associated with programs transferred to tribal operation (above and beyond the contract support costs paid as part of indirect costs). Such costs are administrative costs which, according to the DOI Office of Inspector General, are not properly placed within a Tribe's indirect cost pool (since they benefit specific BIA programs, rather than generally benefitting all tribally-administered programs). IHS historically has paid direct contract support costs separate from indirect costs, and as discussed further below the BIA is currently reviewing its position in advance of FY 2000.

The Workgroup roughly estimates that the total direct contract support cost burden not paid by the BIA may well be in the range of \$28 million.¹ Putting aside this omission, the BIA anticipates that appropriations in FY 1999 will only be sufficient to fund 83% of all tribal needs for indirect costs associated with BIA programs transferred to self-determination and self-governance tribes (\$115 million in funding distributed across \$139 million in need). But, when the excluded direct contract support costs are factored in (\$167 million in need), the total BIA FY 1999 funding for contract support drops to 69% of need, with a \$52 million shortfall. Further, if the law enforcement programs added by Congress in FY 1999 are factored in (under the current moratorium the BIA is unable to turn these programs over to tribal operation), the shortfall increases substantially.² As a result (and as long authorized by the appropriations committees), Tribes will continue being compelled to divert their already severely underfunded Tribal Priority Allocation (TPA) programs to cover the Bureau's shortfall.

The NCAI Workgroup strongly urges Congress to close this tremendous gap in FY 2000, and thus relieve TPA programs of the burden of paying BIA's contract support

¹The amount stated is an estimate only. The Bureau is presently studying the issue of contract support costs and expects to have more accurate estimates shortly.

²The BIA is presently calculating the precise amount. Also, the figures set forth here do not include any further adjustments that may become necessary to accommodate the rulings of the Tenth Circuit Court of Appeals in *Ramah Navajo Chapter v. Babbitt*.

obligation.

**BIA CONTRACT SUPPORT COST-RELATED
INITIATIVES IN FY 2000**

The President's FY 2000 budget request for contract support costs includes a very modest increase of \$6.4 million to address the Bureau's continuing contract support cost shortfall, plus \$5 million for the ISD Fund to address the contract support cost needs of Tribes taking on new BIA programs.

These sums are woefully insufficient to make any meaningful inroad into a shortfall that continues to penalize Tribes which elect to operate BIA programs under the Self-Determination Policy. As noted earlier, they are also insufficient to cover the contract support costs associated with the new FY 1999 tribal law enforcement initiatives to be transferred to Tribes in FY 2000.

Congress and the Administration are respectfully urged to revise these sums in FY 2000 to finally close the gap in contract support cost funding.

In planning for FY 2000, the Bureau is consulting with the NCAI Workgroup and the Indian Health Service in the development of a formal contract support cost policy. Among other matters, the Bureau is reviewing the issue of direct contract support costs, and how such costs might be recognized and paid in the future. One element under consideration in this regard is the possibility of moving such costs to an appropriate program activity in the budget, rather than lumping them in with other contracts, since such costs are directly associated with the programs under contract.

**IHS CONTRACT SUPPORT COST-RELATED
ACTIONS IN FY 1999**

During the first third of FY 1999, IHS has been engaged in an intensive effort to improve the accuracy of its data on tribal contract support needs and funding levels. In the course of this work IHS has been able to eliminate a large number of financial reporting errors caused by a variety of problems. As a result of these efforts, IHS has determined that the ongoing shortfall for older tribally-operated IHS programs is \$27 million, rather than the \$35 million previously reported to Congress.

IHS has also engaged in an aggressive process to finally negotiate all contract support cost requests relating to "new" programs, requests that have, until now, simply been placed without any scrutiny on IHS's "queue" (or priority list) for deferred contract support cost funding in future years. The process of finalizing the "queue" amounts with Tribes involved serious arms-length negotiations leading to substantial reductions in the size of the queue, from an initial estimate in excess of \$70 million down to \$59.9 million.

In the course of its analysis, IHS has also uncovered and sought to correct inconsistencies with the way in which IHS's Area Offices have previously carried out internal IHS policies regarding the re-distribution of contract support cost funds when individual tribal indirect cost rates move up or down.

As of this writing, IHS is reportedly three weeks away from completing its analysis and making a final decision regarding the distribution of its FY 1999 contract support cost funds. Going into the FY 1999 distribution process, IHS reports that contract support funding for individual Tribes presently ranges between zero for some tribes and very low percentages for others, up to 90 and 100 percent for others. Assuming IHS's remaining audits and negotiations are consistent with the work undertaken thus far, and assuming IHS follows the FY 1999 distribution plan recommended by NCAI and the IHS Contract Support Cost Work Group (CSCWG), IHS will be able to narrow the range in contract support cost funding in FY 1999 to between 70% and 100% for all tribally-administered IHS programs.

Significant work went into determining how to equitably spread the limited \$35 million increase in contract support across the \$59.9 million worth of recent tribal programs carried on the IHS "queue." Initially, it was suggested that IHS would only be able to substantially narrow the gap in contract support funding by disregarding the statutory category of contract support costs known as one-time "startup" costs (and then paying all "queue" programs an equal share of the increase). Tribes objected strongly to disregarding this statutory entitlement, particularly since Tribes had relied on the Act and on past IHS policies recognizing such costs. Instead, NCAI and the CSCWG urged IHS to look beyond the "queue" amounts, and to examine each Tribe's total contract support cost funding shortfall (including shortfalls associated with older programs not waiting on the "queue" for contract support). (Most Tribes operating programs on the IHS "queue" also operate older programs that are not on the "queue.") NCAI urged that this full picture be considered in deciding whether and how much to fund each Tribe's "queue" entitlement.

IHS tentatively reports that if the NCAI approach is taken in FY 1999, no Tribe will receive a partial payment on its contract support entitlement lower than approximately 70% of statutory need. Further, no Tribe's contract support will be reduced (except to the extent of a reduction in a Tribe's indirect rate) -- a major source of wide-spread Tribal and IHS opposition to the abandoned proposal to reallocate all contract support costs nationally on a flat pro-rata basis. If this analysis holds, IHS will also be able to avoid any different treatment for Tribes that only began operating IHS programs in FY 1999; rather, *all* Tribes will receive between 70% and 100% of their need, with the overall weighted average at 80.35%.

Despite the substantial improvements achieved this year, in FY 1999 IHS reports that there will still be a combined contract support cost shortfall of \$52.3 million as of

October 1, 1998.³ If inflation is included for FY 1999 and FY 2000 (\$26 million at 5% per annum), and if \$15 million is added for anticipated new contracting activities, the total need going into FY 2000 will be \$93.4 million. Even still, this figure disregards unpaid inflation associated with direct contract support costs for FY 1994 through FY 1998.

IHS CONTRACT SUPPORT COST INITIATIVES IN FY 2000

The President's budget request includes a \$35 million increase in contract support associated with IHS programs under tribal operation. Based on current levels of contracting, such an increase would certainly boost the levels of contract support payments to many Tribes. But even if inflation is disregarded, it would still leave scores of the least funded Tribes underfunded in the range of between 10% and 20%, depending upon which of several possible methodologies is used to distribute such an increase. (Possible methodologies include helping all underfunded Tribes cover varying shares of their shortfall, as well as methodologies directing all such new funds only to the most severely underfunded Tribes.)

As of this writing Congress has not begun to consider the FY 2000 budget. It is unknown whether Congress will lift the section 328 moratorium in whole or in part. For its part, IHS is now actively exploring with Indian country possible alternatives, including approaches which view FY 2000 as a second "transition" or "correction" year in which the lion's share of any effort continues to go toward addressing the ongoing contract support crisis faced by existing tribal programs. These and other reform issues are being actively explored as part of IHS's initiative to revise the agency's contract support cost circular for FY 2000 by April 1999.

As with the BIA shortfall, the NCAI Workgroup strongly urges Congress to fully close the gap in the current IHS shortfall for FY 2000, estimated by IHS to be \$93.4 million plus unfunded pre-1999 inflation. As part of this effort Congress should restore the ISD Fund to at least \$12.5 million in FY 2000, and IHS should immediately begin canvassing Indian country to secure an assessment of new contracting requirements needed for FY 2000 and FY 2001.

DETERMINING CONTRACT SUPPORT COST NEEDS

The Indian Self-Determination Act mandates that, as part of the Federal-Tribal partnership embodied in the Indian Self-Determination Policy, the IHS, BIA and other federal agencies must transfer, to the extent possible, all of their administrative functions associated with carrying out a program. But it is not always possible to transfer such programs, either

³For the most part, IHS calculations are based on a snapshot taken at the end of FY 1998.

because Congress has prohibited it (as is the case with transferring tribal shares of the BIA Central Office), the agency has resisted it (as is the case with many BIA and IHS Area Office operations), or the function is lodged at a location within the Department (or other federal agencies such as the GSA, OPM, Treasury, DOJ, DOL, EPA, etc.) not accessible to Tribes.

To bridge the gap, the agencies and Congress have endorsed an approach in which most contract support cost needs are determined through the arms-length negotiation of an indirect cost rate (usually with the DOI Office of Inspector General, or "OIG").⁴ Additional one-time start-up costs and (in the case of IHS only) recurring direct contract support costs, are negotiated directly with the funding agency. (As noted earlier, the BIA has not recognized a separate entitlement to such costs.)

This system has been closely scrutinized time and again throughout the life of the self-determination initiative. In each instance it has been reaffirmed. Nonetheless, the Workgroup has spent considerable effort exploring whether any reforms in this system are warranted to provide additional assurances of fairness, equity and efficiency. In doing so, the Workgroup has operated under a set of key governing principles, providing that changes in the current contract support cost system must:

- ✦ maintain and promote the fundamental right of Tribes to self-determination, as specified in the self-determination and self-governance laws;
- ✦ protect each Tribe against any reduction in contract support costs that a Tribe currently receives;
- ✦ promote equity among Tribes while respecting tribal choice, local flexibility and varying circumstances;
- ✦ promote sound management practices that encourage efficiency; and
- ✦ maximize simplicity in application wherever possible, consistent with the other governing principles.

As of this writing, work on possible reforms to the system for determining contract support cost needs is still underway, and a number of reforms are under active consideration. While some are minor and relatively simple, others will require a level of intense study and casework application that may well be beyond the scope and resources of the Workgroup (such as reforms requiring research and field testimony of a "benchmarking"

⁴A relatively small number of Tribes (including several operating large IHS programs) negotiate their indirect cost requirements with the DHHS Division of Cost Allocation (DCA). Despite repeated requests, DCA has refused to participate in the work of the NCAI National Policy Workgroup.

system that might establish consistent but non-binding funding guides for certain categories of contract support).

One possible reform recommendation already being tested by many self-governance Tribes is the negotiation of firm "base budget" amounts for a period of years, including a set amount of contract support. This approach holds some promise for promoting longer term stability, while rewarding tribal management efficiencies. This and other possible reforms are intended to maximize incentives for efficiency in Tribal operations consistent with generally accepted management principles for non-profit health and social service institutions.

Although some short-term reforms may ultimately be recommended, together with longer-term studies on other reforms, the Workgroup's conclusion thus far is that determining the bulk of contract support cost needs through arms-length Tribal-OIG and Tribal-DCA negotiations continues to be the best means for safeguarding the public fisc while assuring that tribal contract support cost needs are covered for all "reasonable and necessary" amounts required for "prudent" administration of transferred programs, as specified in the Act. At the same time, Tribal-specific negotiations also respect tribal flexibility and choice, recognizing that Tribes of varying size, location, circumstance, history and tradition operate in a variety of ways, representing a diversity to be accommodated, respected and encouraged.

FUNDING CONTRACT SUPPORT COST NEEDS: PAST, PRESENT AND FUTURE

For past years, the Workgroup has concluded there is little Congress can or ought to do to address the government's past liability for IHS and BIA failures to meet their statutory contract support obligations. To the extent Tribes incurred damages, it is for the judiciary or other adjudicative bodies to determine the appropriate relief. Indeed, in cases such as *Winstar* the Supreme Court has time and again cautioned about the grave contractual and constitutional problems posed by Congressional efforts to repudiate past government contract obligations.

As for the present, the Workgroup calls upon all interested parties to once again embrace the Federal-Tribal partnership embodied in the self-determination and self-governance initiatives. Contracting and self-governance Tribes must not be penalized relative to other "direct service" Tribes by being compelled to "rob Peter to pay Paul," to reduce health and social service programs already underfunded at 40% to 60% of need, in order to cover the federal commitment to sustain contract support. An immediate and aggressive effort must be made now to close the current gap and thus keep faith with Indian country.

Turning to the future, Congress is already witnessing a significant slowing

down in the rate at which IHS and BIA programs are being transferred to tribal operation, notwithstanding that the bulk of each agency's programs remain today under federal operation. There are many reasons for this leveling off in self-determination and self-governance activities. In some parts of the country Tribes remain deeply suspicious of the self-determination initiative, viewing it as a poorly disguised move toward outright termination of the Federal-Tribal trust relationship. Other Tribes see the local agency operations as terribly underfunded and are loath to step into the federal government's shoes under such circumstances. Still other Tribes are satisfied with the agencies continuing to operate various programs, particularly where the Tribes feel they have secured substantial involvement in how each agency carries out its responsibilities. Finally, some Tribes do not feel they possess the resources or capabilities to operate certain programs on their own. Whatever the reasons, it is clear that a certain equipoise is being reached between the level of contracting activities and the level of agency direct operations.

This is not to say that new contracting and compacting is about to stop in 1999. For one thing, Congress's moratorium is no doubt producing somewhat of an artificial backlog that will now have to be addressed, with two years' growth being dealt with instead in one year. In addition, as Congress moves forward to remedy the greatest problems in Indian country, new programs will demand new contract support since self-determination and self-governance Tribes will fold those programs into their existing operations. Finally, from time to time there are likely to be contract support "spikes" that occur when Tribes such as the Navajo Nation or the Cherokee Nation move forward to take over the operation of large agency programs not presently under tribal operation.⁵

With these caveats in mind, overall the rate of increase in contracting activities across the country is reducing. While the FINAL REPORT will explore further the causes of this trend, the fact is that the BIA in recent years has never exhausted its \$5 million annual ISD Fund, and the IHS is now tentatively estimating that its own growth will drop close to approximately \$12.5 million per year (a marked decrease from years past).

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⁵Although it has been suggested by some observers that fully funding contract support will substantially increase the willingness of Tribes to contract more programs, the IHS experience with the "queue" demonstrates that relatively few Tribes make the "contracting" decision based primarily on the availability of contract support funding, although this factor certainly plays a role.

STATEMENT OF ORIE WILLIAMS, EXECUTIVE VICE-PRESIDENT, THE YUKON-KUSKOKWIM HEALTH CORPORATION

Mr. Chairman, thank you for the opportunity to testify before your Committee on what Congress ten years ago called "the single most serious problem with implementation of the Indian self-determination policy," namely the failure to fully fund contract support costs.

To begin, my name is Orie Williams, and I am the Executive Vice-President of the Yukon-Kuskokwim Health Corporation. Our health care organization is authorized by and represents 58 federally recognized Alaska Native Tribal Governments, their members and their village communities, and we are the second largest tribally-operated IHS program in America. We also believe we are the most successful tribal operation in the country, whether measured in terms of improved patient care, improved health status or increased tribal control over the health care delivery system.

Having said that, I must state that I truly believe it will take the next 10 to 20 years of sustained resources to build healthy families and communities in our service area and to totally transfer service from an IHS crisis care model to a health prevention model. This must—and can only—be accomplished under tribal management with the flexibility Congress has allowed in the amendments to the Indian Self-Determination and Education Assistance Act demonstration model. We applaud Congress' vision and the tribal vision that made this Act a reality.

We face daunting conditions. The 58 villages and 23,000 people we serve are spread across an enormous, roadless area the size of South Dakota. Only snowmachine and subsistence trails, rivers and air transport systems connect our communities. Transportation during the long harsh winters is unpredictable. The majority of our people live below the poverty line. We estimate at least 54 percent are eligible for Medicaid insurance coverage; overall, 44 percent are unemployed, although in many villages the unemployment rate exceeds 80 percent. Most of our village homes have 6 gallon plastic buckets for toilets. Post-neonatal mortality is more than double the U.S. rate. Death by suicide is four times the national rate. Fetal alcohol syndrome and fetal alcohol effect are extraordinarily high, as are all other alcohol-related diseases, accidents and deaths. Hepatitis, tuberculosis, infections caused by lack of adequate sewer and water systems, and sexually transmitted diseases all plague our young and growing population.

Attached to my testimony is a detailed profile of our health care organization and our region. As the profile reflects, we have succeeded in improving the health care delivery system since the days of IHS operation. But part of the reason we cannot do more today is that IHS has required us to neglect some programs and to divert resources to cover the fixed administrative overhead that necessarily comes along with operating a \$40,200,476 system comprising 1,003 employees, 47 village community health aid clinics, one mid-level subregional clinic, and a 51-bed hospital (including two new sub-regional mid-level clinics under construction).

Our contract support cost requirement—what we need according to IHS policy, the DHHS Division of Cost Allocation and our certified annual audits—is \$14,925,949. This is what we need to run our financial management systems, to operate our personnel, human resource and payroll systems, to support our facilities, to cover insurance, legal and audit costs, to operate our procurement system for drugs, equipment and supplies, to sustain our third-party billing operation, to support needed technology, to advance employee training, and to respond to new regulatory and legislative initiatives.

But for several years we have operated with a multi-million dollar deficit in contract support costs, a deficit this year of \$2,304,663—or fifteen percent (15%) below what we need (per Alaska Area CSC shortfall report 1/8/99). Keep in mind that this "need" has been determined by IHS and its sister agency the Division of Cost Allocation, not by us. Frankly, in our opinion it is artificially low. For instance, it understates greatly the need to at least match IHS's fringe benefit package when a tribal organization takes over the IHS system, especially for Commissioned Corps employees and Civil Service employees.

The continual backlog in unpaid contract support costs has had serious consequences. Our accounting department is \$212,050 short, including three unfilled positions. Our billing and admissions departments are \$321,375 short, including six unfilled positions. Technology support is short \$236,700, representing three positions that support the remote telecommunications system that is the central nervous system of our health care operation. Hospital maintenance and housekeeping staff and equipment are down \$477,430 to name just some of the areas where the shortage is causing reduced performance. We are unable to use IHS "tribal share" program funds for their intended purpose because much of the funds have been di-

verted to help close the contract support gap, funds which should be going to regional substance abuse services, mental health services, home health care and village clinic operations, and inhalant treatment, to name a few. In short, Mr. Chairman, the contract support cost shortfall for YKHC is very real, and it is causing very real damage to our ability to further improve the health status of our people.

With this overview, we would like to make these additional points directed at the issues raised in the Chairman's letter: how to improve upon the system itself within the framework of the Indian Self-Determination policy.

1. First, I cannot let this opportunity go without commenting on last year's proposal to reallocate all contract support costs on a simple flat pro rata basis.

The flat pro-rata approach would have been a disaster for many tribes, and tribal organizations, across the country that have worked hard over the years to justify and secure the contract support funding they have. For us, our existing shortfall would have only gotten worse, causing massive layoffs in a region of Alaska already plagued by a fisheries disaster and low employment. Other tribal organizations that depend on the stability of a known contract support cost amount each year would have been hurt even more.

If there is one thing I would hope to convey today, it is that last year Congress wisely rejected the proposal to redistribute all contract support on a flat pro rata basis. It is an approach that would have made Indian country shoulder the Federal Government's burden. It is an approach that was wrong despite its best intentions, and I hope the Chairman, and this distinguished Committee can assure all of us that it is an approach that will not be revisited.

It is true that this system seems to work reasonably well for the BIA. But that is only how it appears. The fact is, the BIA system is peculiar indeed. Under that system, the BIA supposedly pays a tribe its full indirect costs the first year, along with its full start-up costs. But in the second year the tribe's payment can drop to 80 percent, 70 percent, or some other level no one knows until the BIA actually calculates it the following summer, just before the fiscal year is about to end. The BIA payment goes up and down with no predictability, causing considerable uncertainty for the tribes. In fact, I understand that this is a large part of the reason why the Interior Board of Contract Appeals threw out the BIA system. It ruled that if a tribe's contract calls for contract support costs, and the tribe is dutifully performing, and most of the year is over, the tribe must be fully paid. There is only one thing I can say for the BIA system: It is administratively convenient.

The BIA system may help the BIA. But it does not help tribes. In contrast, the IHS system, although flawed by erratic appropriations, represents a genuine effort to maintain tribal stability by continuing to pay each tribal organization at least the same amount it received in the preceding year, again beginning with an effort to fully pay the tribe in the first year.

Yes, the IHS system can be improved upon, especially with better coordination between Congress and the Tribes; but it is clearly a better system—assuming the goal is the stability of health programs serving needy Native Americans, and not administrative convenience.

2. Second, we believe the Committee's concern regarding accurate data from IHS has been largely addressed in the past year. We are extremely impressed with IHS's commitment and progress in this area over a few short months, thanks to a needed centralization of much of this work, improved training of IHS Area personnel, and greater oversight from the IHS Office of Tribal Affairs and the Division of Financial Management. Candidly, we were one of many who said that IHS would never be able to bring accuracy back into its system and to negotiate all the contract support requests it had before it. But our skepticism was misplaced, and we give credit for this especially to OTA Director Doug Black and Deputy Director Ron Demeray, as well as Carl Fitzpatrick, Dan Cesari and Dan Modrano of the IHS Division of Financial Management.

We do want to emphasize two points regarding the data issue. First, during last year's debate IHS furnished undistributed data to the Appropriations Committee staff. It was never publicized. Neither IRS nor anyone else shared that data with Indian country. It was finally provided to us by diligent Congressional staff during the heated debate; and, once it was received, we were able to show how terribly flawed the data was, and fortunately decisions based upon that poor data were abandoned. In the meantime, however, statements were made on the floor of the House and elsewhere that were plainly in error based on this false and misleading information.

The point is this: the IHS and the Congress need to trust us. They need to share such vital information with us in advance, and at their own initiative, not ours. If the data withstands the harsh scrutiny of daylight, it can be the basis for informed

decisions. Otherwise, Congress should step back and hesitate to act on an uncertain record that has not been tested.

Indeed, even with all the good work IHS has done over the past few months, we continue to probe, to ask questions, to find flaws, to point out inaccuracies, and to prompt IHS to improve its data further. Tribal health care providers are now in partnership with IHS in this endeavor, and I have no doubt that IHS will readily acknowledge the value of our contribution. After all, we have a vested interest: if the data is called into question, the whole system may be called into question. And none of us can afford that outcome, least of all the thousands of Alaska Native people in the 58 villages we serve.

3. Third, we share the Committee's interest in learning more about the issue of agency downsizing. While we at YKHC are not in a position to assess IHS's downsizing nationally, we do know that it has happened in the Alaska Area and in our own Y-K Delta Service Unit in Bethel.

At the service unit level, there is no longer any IHS presence. *Everything that was part of IHS has long been taken over by YKHC through our Compact with Congress.* Of course, that does not mean IHS does not exist, for the hospital facility we operate is owned by IHS, and many of the professional staff we use are IHS employees detailed to us under the Intergovernmental Personnel Act and other applicable law. We do this because for many positions we simply cannot match the compensation benefit packages available to IHS for attracting qualified medical personnel, especially when it comes to Commissioned Corps personnel. So we leave those positions with IRS and we enter into agreements detailing those positions to YKHC. To that extent, then, IHS still has a vital local presence in the Yukon-Kuskokwim Delta.

At the Area level, in 1994 we helped set into place a three year process for transitioning most of the Area Office operations to the Area's several tribal organizations and individual tribes. The process has worked well, and has been coordinated with the Alaska Native Tribal Health Consortium's and the SouthCentral Foundation's take over this year of the Alaska Native Medical Center. As a result of all these carefully planned efforts, the Area and ANMC staff working under the direction of IHS has shrunk from over 1,350 in 1994 to about 40 today. We believe this example—the first experiment of its kind in the Nation under the Self-Determination Demonstration Act, involving the tribal administration of an entire Area and all its constituent service units—certainly demonstrates that IHS operations shrink as Congress permits tribes to step into IHS's shoes.

On a national basis, the reduction of the IHS bureaucracy may be more difficult to see. For one thing, tribes have not been as consistently aggressive in the other IHS Service Areas in exercising their rights under the Indian Self-Determination Act in part due to the fact that they are not willing (or perhaps, more accurately, able) to take on services without adequate contract support appropriations, including start-up funds. Moreover, even where Self-Determination transfers have occurred, the reductions in the IHS system have often been balanced out by expansions in the overall system, thanks to desperately needed congressional attention to the terrible shortfalls in health care funding facing Indian country. For instance, in assessing IHS's reductions, it must be noted that Congress has increased the IHS service budget from \$226 million in FY 1975, to over \$1.84 billion in FY 1999. So, although 40 percent of IHS may now be under tribal operation, the remaining 60 percent is many times larger today than was the entire agency in 1975. In short, it may well be that far more analysis is needed to determine whether IHS is in fact a much smaller agency than it would otherwise be in the absence of the Indian Self-Determination Act.

Nonetheless, one thing remains clear. In 1988 this Committee and the Senate Indian Affairs Committee observed that the IHS service bureaucracy had been gradually replaced with an oppressive contract monitoring bureaucracy. Since then, especially with the advent of the 1994 amendments, we have seen a real reduction at our Area level, and a corresponding transfer of functions to the tribal providers. But we still believe more can be done at the Headquarters level in this regard, and that Headquarters can and must also do a better job of freeing up all available Headquarters resources that support the system, including assessments paid to other agencies.

As for other Area Offices outside our own, it is clear to us that IHS is indeed holding on to its empire in some quarters, and that it is often reluctant to turn over its operations to tribal control. This has been particularly evident in the Phoenix, California and Oklahoma Areas, and it is fair to say that IHS Headquarters has failed to bring necessary leadership and consistency to the various Area and Headquarters determinations regarding appropriate levels of noncontractible, so-called "residual," "inherently Federal" functions. Adding to this particular problem, IHS continues in some Areas to also withhold from tribal operation so-called "transi-

tional” operations (this is so in the Portland and Oklahoma Areas, among others), despite the ruling of at least one Federal court that such actions are indefensible and contrary to the Self-Determination Act. This type of paternalistic approach has helped foster an “us versus them” attitude and an attempt by some to divide Indian country and pit one region of the United States against another.

In sum, we recognize that IHS has substantially downsized in response to the Self-Determination Policy, but agree that more along these lines can and must be done.

4. Fourth, the Committee is correct that more can be done to accelerate the transfer of additional functions from IHS to the tribes. Under an IHS plan adopted two years ago, IHS now takes up to three years to transfer functions from Federal operation to tribal operation. This never used to be the case, and functions were always transferred within a matter of months. That’s the way it was with the transfer of our Y-K Delta Regional Hospital. But this new plan, adopted at IHS insistence over the objection of many tribes, represents a serious retrenchment clearly intended to protect the Area and Headquarters offices. It is also directly contrary to the Act, which mandates that all IHS functions be paid to a contracting tribe as soon as the contract goes into effect.

5. Fifth, we share the Committee’s interest in learning more about how much the Federal Government really spends to support an IHS-operated clinic and hospital. However, we are skeptical this information can be reliably developed in the short term. After all, innumerable Federal agencies confer some benefit on IHS in one way or another, be it the Department of Justice (in prosecuting collection litigation, defending cases and other matters), the General Service Administration, the Office of Personnel Management, the Department of Treasury, the Veterans Administration (as in negotiating pharmaceutical contracts), the Equal Employment Opportunity Commission, the Federal Labor Relations Board, the Government Ethics Office, the Merit Systems Protection Board, the Government Printing Office—the list goes on and on.

We assume the goal of such an ambitious study, perhaps better undertaken by the General Accounting Office than IHS, would be to provide some meaningful comparison between the true Federal costs of IHS administered care, and the total costs of tribally administered care, including contract support costs.

Although the results of such a study would be enlightening, we respectfully suggest that such a study may ultimately be of limited use, particularly given its likely cost. For one thing, the Act and other Federal laws impose upon tribes financial obligations which do not burden IHS or any other branch of the Federal Government.

For example, tribes undertake detailed annual audit reports on all their operations. IHS does not. Tribes carry costly property and vehicle insurance, casualty insurance, errors and omissions insurance and other insurance outside the scope of strict Federal tort claims. IHS does not. Tribes bring in outside risk managers to help secure and maintain accreditation and to administer sound programs. IHS does not. Tribes bear the costs of their governing bodies which develop tribal health care policy in the same way that Congress controls policy for IHS. IHS does not. Tribes renegotiate their compacts and contracts every year. IHS does not. A study of the true cost of Federal administration will miss these tribal-unique costs.

But even more importantly, the Indian Self-Determination Policy was never designed as a way to save the Federal Government money. It was built with the goal of promoting tribal responsibility and accountability. The Act directed that Federal paternalism and oppression must end, and that Washington must stop dictating what is best for Indian country and what is best for the health care needs of Indian people. And to that extent the policy and its execution have been a resounding success. Having come so far from where we began, we must not now let ourselves be diverted from that success by a preoccupation with whose system costs less, especially given so many variables in program delivery and facility types.

Nonetheless, we concur in the Committee’s interest in exploring how tribes and IHS can be encouraged to maximize their efficiency in all operations. One way to do this is to guarantee to a tribe a stable flow of funding for a period of years. After all, maximizing efficiency first requires predictability and stability. If a tribe had a multi-year budget that was, in fact, actually funded, a tribe would be free to trim further its administrative overhead as much as prudently indicated, for the reward would be for the tribe to retain any savings, to be plowed back into expanded health care. IHS is already experimenting with this approach, known as the “base budget” approach, with several tribes, and the proposed permanent Self-Governance legislation would clarify IHS’s authority to do so within the Self-Governance program. The Committee may wish to encourage IHS to explore the same avenue for ordinary contracting tribes.

6. Sixth, the Committee has asked for comments on how tribes could further improve the availability of health care services within their existing budget limitations, and has particularly asked whether new authority or flexibility is needed to achieve this goal.

At YKHC we have experimented with a number of recent innovations, and we would be pleased to share these innovations in greater detail with the Committee and other tribes. For instance, we have invested in staff housing so that we can attract and maintain professional staff and reduce the turnover that plagues most health care operations in Indian country. We have changed the way we do business for the extensive travel required as part of our health care delivery system, to further reduce costs and conserve our resources. We have created our own emergency air medivac system, in lieu of expensive private carriers. We have worked with city governments and commercial lending institutions to finance long term facility infrastructure using municipal bonds, saving millions in financing and interest. We are working cooperatively with the State of Alaska Department of Health and Social Services to maximize program delivery of early child intervention and developmental health programs as well as State funded substance abuse and mental health services. The Self-Determination and Education Assistance Act has proven beyond a doubt that when adequately funded, Tribes are the best health care providers not only for their own Native people, but for all members of our communities.

These and other local innovations have helped us stretch our limited dollars far beyond IHS's ability. Our Tribes are proud and able to take the responsibility afforded them under our Compact with this Congress. All we ask is that Congress allow us the same resources you would want in providing health care to your own families.

Substantial additional innovations will come with the enactment of the pending permanent Self-Governance legislation that I understand either has been or will be introduced this week. While the legislation is detailed, such detail is necessary if we are to overcome the barriers in Federal law and policy that make doing business much more expensive for tribal health care providers than it needs to be. Given the extraordinary scrutiny this legislation was given last year in the form of H.R. 1833, we respectfully hope the Committee will be able to move the new legislation rapidly to a mark-up early in the Session.

Along similar lines, Title VI of the same proposed new Self-Governance legislation should eventually open the door to important new programs currently administered by the Department of Health and Human Services outside the authority of IHS. Title VI puts into place a study which hopefully will lead to additional legislation in the years ahead. While we would have preferred moving directly into a demonstration program with the Department, as originally proposed in H.R. 1833 as introduced last year, the Department has insisted that any demonstration program be preceded by careful study. Again, we hope this Committee will move swiftly on this important new bill.

Finally, we are confident that tribes can bring considerably more resources into their systems, and can do so more efficiently, once the Medicaid demonstration program established in the Indian Health Care Improvement Act is expanded to all tribal health care providers, as now proposed in S. 406.

7. We would like to close by commenting on the last topic identified by the Chairman, how to fund contract support costs today and in the coming years.

This Committee helped give birth to the Indian Self-Determination Policy a quarter of a century ago. What we need today as tribal health care providers, first and foremost, is a resounding and unequivocal recommitment of the Nation to that policy. In the area of contract support costs, we respectfully believe that that commitment means fully funding existing contract support cost needs.

It is important that the Committee understand fully the current situation. As things now stand, tribal health care providers are actually punished for operating IHS programs. If they want to operate an IHS program, if they want to take on responsibility for the program, if they want to realize improvements in the local health care delivery system, if they want to break the cycle of paternalism and dependency, there is a price: the tribes must finance their contract support cost shortfalls out of the program itself.

This would not be acceptable even under ordinary circumstances, and circumstances here are far from ordinary. Already IHS programs are funded at between 40 percent and 60 percent of need. Already, Indian health care is funded at less than half the national per capita expenditure on health care for other Americans. It is remarkable, to say the least, that under these circumstances tribes in our part of the country living in "third-world conditions" should be required to further reduce their programs in order to realize the benefits of improved health care and local autonomy that come with the Indian Self-Determination Act. IHS has provided

the Committee with an estimate of the increase needed to fully fund contract support through FY 2000 (including inflation adjustments for FY 1999 and FY 2000), and we respectfully urge the Committee to support a full increase in that amount in its communications with the Budget Committee and the Appropriations Committee.

For the future, there is every indication that the rate of increase in contracting activities has now come down substantially, and will likely carry a contract support cost of between \$10 million and \$15 million for the Indian Self-Determination Fund funding each year. Proportionately, this is consistent with the size of the ISD Fund in the mid-1990s, and we therefore believe it is reasonable for Congress to commit to continue funding new contracts at that level for many years to come.

Most importantly, we have been unable to identify any systemic problem either in the general Self-Determination process or in the specific contract support cost process. We therefore respectfully caution the Committee to reject recommendations that would revamp the Self-Determination Act in significant ways, such as by deferring new contract starts, deferring tribal entitlements to receive contract support, or otherwise weakening the Act's contract support cost provisions.

Improvements, however, can certainly be made in how the Act has been carried out. For instance, IHS and BIA can report to Congress on a more timely basis the contract support cost needs anticipated both for the current year and the upcoming new year, so that Congress can more easily make corresponding adjustments in the supplemental and ordinary appropriations processes. While there is no indication that the contract support shortfall has been caused by a lack of information regarding its extent—a shortfall that has been regularly reported to Congress, the Secretary and OMB, and that has long been well-known—certainly more accurate, detailed and earlier reporting will lead to correspondingly better decisions here. Given the progress IHS has made in its data collection this year, working with the National Congress of American Indians and Tribal technicians, consultants, and Tribal attorneys, this is not an ambitious request.

We also believe the agencies can do a better job of refining and standardizing the process for determining contract support cost needs. The National Congress of American Indians is already looking into this area, and we look forward to NCAI's recommendations later this year. YKHC certainly supports standardization that is sensitive to areas of commonality among tribes, as well as being sensitive to the unique differences among us. After all, no one would quarrel with the fact that our contract support cost needs are necessarily higher given where we are located than an identically-sized program within a casual drive outside Phoenix, Minneapolis or Seattle.

Finally, Mr. Chairman, we would ask that you and this Committee do everything possible to elevate the position of Director of Indian Health to the Assistant Secretary level—a tribal request that is long overdue.

Mr. Chairman, we thank the Committee for the opportunity and honor of testifying today on an issue that is directly affecting the health and welfare of thousands of Alaska Native and non-native people back home, and of millions of Native American people across the country. We look forward to working closely with the Committee as it continues its examination into the Self-Determination contracting and compacting processes, and to exploring all avenues for continually strengthening both the Nation's Self-Determination policy and the ultimate delivery of the highest quality health care services possible to our people at home.

YUKON-KUSKOKWIM HEALTH CORPORATION

A. ORGANIZATIONAL DESCRIPTION

Yukon-Kuskokwim Health Corporation (YKHC) is a private, non-profit 501 (c) (3) health organization that delivers primary care, educational, preventive, and planning services to the people of the Yukon-Kuskokwim Delta (Y-K Delta). Funding for the Corporation is primarily provided through the Indian Health Service (IHS) via the Alaska Area Native Health Service and the State of Alaska for designated programs.

Organized in 1969 as part of the Office of Economic Opportunity's effort to develop consumer controlled health organizations, YKHC started with four programs. Until recently, providing more than 30 programs, YKHC operated as a federally-designated contractor under P.L. 93-638, the Indian Self-Determination and Education Assistance Act of 1975. In January 1995, under the Self-Governance Demonstration Project, YKHC began to provide its health delivery services through the Alaska Tribal Health Compact, an all-Alaska Tribal self-governance agreement with the IHS.

The YKHC service area population is 22,753 (Source: AK Dept. of Labor, 1998) and encompasses parts of three census districts (Bethel, Wade Hampton and Yukon-Koyukuk). The service area is divided into 11 units representative of the Y-K Delta. Under the Alaska Tribal Health Compact YKHC serves 58 federally recognized Tribes, acknowledged through continuing Tribal Resolutions for provision of primary health care services on their behalf.

The voting members of the Board of Directors are Y-K Delta Alaska Natives (Yup'ik Eskimo and Athabascan Indian) representative of the region's villages. The Board is authorized as the chief policy making body of the Corporation and exercises overall control, management and supervision of the organization.

The YKHC's mission statement reads: "To achieve the greatest possible improvement in the health status of the people of the Yukon-Kuskokwim Delta Region of Alaska. We are committed to the development of culturally relevant programs for primary care, prevention and health promotion in a setting that fosters Native self-determination in the control and management of health delivery."

The Yukon-Kuskokwim Delta is located in Southwestern Alaska, approximately 400 air miles from Anchorage. Encompassing 75,000 square miles of coastal wetlands, tundra, and mountains, the Y-K Delta Service Area is about the size of South Dakota. The service area consists of 58 tribes living in 50 Eskimo and Indian villages along the Yukon and Kuskokwim rivers and their tributaries. On the Yukon, the YKHC service area boundary begins at the village of Grayling and follows the River to Kotlik where it empties into the Bering Sea. The Kuskokwim River boundary begins at the community of McGrath and follows the river and down the coast to Quinhagak. The boundary includes most Bering Sea coastal villages, as well as the communities on Nunivak and Nelson Islands.

The YKHC's broad range of services and programs include: the Yukon-Kuskokwim Delta Regional Hospital, Clinical, Community and Administration Services. These services offer programs that serve the people of Y-K Delta.

1. Yukon-Kuskokwim Delta Regional Hospital

On October 1, 1991, YKHC assumed the management and operation of the Yukon-Kuskokwim Delta Regional Hospital (YKDRH) through the Indian Health Service P.L. 93-638 contracting process. This regional hospital is a 50-bed general acute care medical facility located in Bethel, Alaska. The facility is a single-story steel frame structure enclosed in 100,000 square feet of space and has a full accreditation by the Joint Commission on Accreditation of Healthcare Organizations. Hospital services include a 19-bed adult medical-surgical ward, an 18-bed pediatric ward, a 7-bed obstetric ward, 6 swing beds (Adult/OB), and the following: outpatient department, emergency room, dental department, eye clinic, pharmacy, lab, X-ray, and specialty clinics.

YKDRH service is based on a unique service plan called "Group Practice". Three wings of the hospital are dedicated to outpatient care, each serving a pre-set group of villages. All patients-according to the villages they are from-are seen in either Group Practice I, II or III. Each patient is assigned a doctor, who will be the patient's physician for as long the doctor is employed by YKDRH. The patient/doctor assignment system at YKDRH is utilized to ensure that the patient's health condition is being monitored by the same health care provider. Group practice seeks successfully eliminating long outpatient waiting periods. It also strives for reducing patients from being seen by a variety of doctors which may create undue lack of knowledge of a patients' history.

The Hospital supports one of the largest field health care programs in Alaska. Presently, 170 Community Health Aides (CHAs) who work in 48 village-built clinics make up the heart of the YKHC health care delivery system. Health aides are predominantly Native Alaskan working in a unique and challenging environment. Living in their home communities, they provide basic health-care services for residents in their villages. CHAs work and consult with the Hospital physician staff via telephone and complex health care cases are referred to mid-level practitioners or physicians through this system. Recent program developments have included the introduction of modern telecommunications equipment that enhance the quality and efficiency of CHAs' patient services.

a. Clinical Services:

Dental provides emergency, routine, and educational dental services.

Dental Disease Prevention provides for Regional Fluoridation Programs, which includes Quality Control, topical fluoride, mouth rinses, and dental health education.

Eye Care provides primary vision care including eyeglasses and contact lenses, diagnosis and treatment of vision disorders and eye disease.

Women, Infants, and Children (WIC) provides nutrition education to pregnant and breast-feeding women, infants and children whose health is threatened by low income and nutritional needs, and provides supplemental foods that can help to correct serious nutritional problems.

Group Practice provides outpatient clinic services for all residents of the Delta. Each Group Practice serves a designated group of villages, and each patient is assigned a physician within the practice.

HIV/AIDS Case Management provides treatment, contact tracking, referral and Sexually-transmitted disease education to patients in an effort to treat or prevent HIV/AIDS.

Sub-Regional Clinics are planned to bring "hospital service" health care closer to the patient populations. A strategically situated sub-regional clinic would be built in a "hub" center surrounded by a cluster of villages. The Clara Morgan Clinic was built (1996) in Aniak and serves 16 tribes and has been operational for over 2 years. Sub-Regional clinics have all the services of a hospital (x-ray, dental, optometry, laboratory, urgent care, pharmacy, etc.) except beds and are staffed by mid-level health care providers and community health aides. Other sub-regional clinics are being planned in two other hub sites, Emmonak and St. Mary's. The purpose of such facilities are to eliminate long patient travel to Bethel and overcrowding at the hospital.

2. Community Services

a. VILLAGE OPERATIONS:

Emergency Medical Services provides Cardio-pulmonary resuscitation (CPR), Emergency Medical Technician (EMT), basic first aid, and other emergency medical services training.

Health Education provides films, filmstrips, videos, and pamphlets on request. The program also provides technical assistance on health education to CHAs, YKHC departments, and local health and social service agencies. In addition, the Health Education Program coordinates a health promotion disease prevention resource center and assists in community health fairs.

Injury Prevention Program promotes injury prevention education and training via presentations to public schools and communities. The Program trains Village Public Safety Officers (VPSOs), Health Aides, and Village Councils in developing village safety regulations, programs and services. The Program emphasizes youth involvement in community injury prevention activities. In addition, the Program serves as a distribution center for a variety of safety related equipment.

Community Health Aide Services:

Physician's Assistant Scholarship Program was created to give an opportunity for Community Health Aides to enter a Physician's Assistant School which contributes to our being able to train local staff to climb higher in their own career ladder goals. In addition, this also contributes to providing more locally trained Health Professionals within our region. With more locally-trained staff we hope to eventually cut the costs of recruitment, relocation and also lower attrition rates.

Health Aide Services delivers primary health care services in 48 village clinics through 170 Community Health Aides (CHAs) and provides a field health monitoring system. The program also assists the CHAs in the areas of Quality Assurance, field support, and Supervisor/Instructors.

Health Aide Training provides training and ongoing education for CHAs. The training includes EMS and CPR certification and ongoing follow-up training.

b. HOME CARE SERVICES:

Home Care Services is a village based program that assists elders and chronically ill individuals with activities of daily living, respite care, chore services, personal care services, and home visits.

c. ELDER ACTIVITY COORDINATOR:

Elder Activity Coordinator is a program developed to ensure that appropriate health care services are being provided to the elders in the region. Elders work with the Coordinator to identify services and activities that are desired.

d. COMMUNITY MENTAL HEALTH SERVICES:

Mental Health provides individual, family, and group counseling and consultation, as well as mental health education and case management services in villages.

Crisis Respite Center is a program which provides emergency counseling and support services for individuals with mental illness. The Center provides evaluation, treatment and referral in a "respite" setting for those individuals needing to be monitored and protected. The program also works closely with the Alaska Psychiatric Institute (State Hospital) for treatment which are not available locally.

Delta Supportive Living is a program which provides housing for "graduates" of the Crisis Respite Center, or the mentally or socially-challenged individuals from the regional community, and teaches them daily living, job seeking and independence skills by providing a temporary apartment while the patient seeks reinstitution "back" into the community.

Residential Diagnostic Treatment Center provides evaluation and short term residential treatment for emotionally disturbed children.

e. REGIONAL SUBSTANCE ABUSE SERVICES:

Phillips Ayagnirvik is a 42 day residential treatment and recovery program for Alaska Natives suffering from the disease of chemical addiction. The treatment plan involves individual, group and family counseling. The program strives to develop culturally responsive individual treatment plans and activities that are proactive and emphasize relapse prevention.

Chemical Misuse Treatment and Recovery Services a village-based substance abuse treatment program focusing on counseling, referral, and recovery support. The program targets people struggling with inhalant/chemical misuse.

Regional Alcohol and Drug Abuse Prevention provides training and technical assistance for Village Alcohol Education Counselors (VAECs), and helps establish village alcoholism programs. The program also provides technical assistance and consultation to agencies.

Community Youth Advocate provides a range of services and activities to the village-based community youth which will aid in prevention of substance use and abuse.

Community Youth Aftercare Specialist is a program with aftercare treatment involving counseling for youth and their families to monitor and encourage abstinence from substance use.

Bethel Alcohol Safety Action Program is a program which counsels members of the Bethel community who were convicted of alcohol-related offenses, on the dangers of alcohol use.

Community Holistic Development provides technical assistance to Y-K Delta communities in the area of holistic health and prevention of substance abuse. Utilizing local resources, the Holistic Development Program conducts presentations on grief processes, youth conferences, healing circles, "Spirit Camps", and other health promotion activities. This program teams with other family-based counseling services to work in communities. Families and individuals are viewed from a systems perspective while integrating the cultural, traditional, and spiritual values of the people.

Fetal Alcohol Syndrome/Fetal Alcohol Effect Prevention Program provides health education, training and support around FAS/FAE issues, and a Teen Outreach Program that provides case management, health education, and support to pregnant and parenting adolescents.

3. Administrative Services

a. TRIBAL AND PROGRAM SUPPORT SERVICES

Tribal Unity and Medicine Gathering is an annual event in which tribal delegates and representatives gather in Bethel by invitation from YKHC to hear YKHC's annual reports, determine tribal health service priorities, and participate in traditional healing and practices by Native healers.

Office of Environmental Health and Engineering is a valuable program which monitors environmental health factors, including waste and well water systems, and oversees all facets of construction and maintenance of the hospital and village clinics.

Remote Maintenance Worker Program provides services in the Y-K Delta by training village water/wastewater operators to properly operate and maintain their water and sewer facilities.

Research & Planning/Grant Writing Resource Center provides technical assistance to YKHC administration, programs and Y-K Delta villages on program planning, funding and evaluation.

Medicaid and Medicare Enrollment village outreach program is designed to facilitate enrollment into entitlement programs.

Media Services provides support to YKHC administration and programs through health-education materials and reports development, publication of a newsletter, videos, and public relations.

b. DEPARTMENT OF FACILITIES AND PLANNING

Facilities & Planning is a program that plans and coordinates all YKHC new construction, maintenance of YKHC-owned properties and buildings, planning for housing for employees.

Village Clinic Coordinator provides assistance to village communities to establish and maintain acceptable health facilities, including planning for and obtaining funding for clinic improvements and facilities operation and maintenance.

B. DESCRIPTION OF SERVICE AREA

1. Health Care Delivery System

The YKHC headquarters is located in Bethel, 60 miles from the mouth of the Kuskokwim River. Bethel serves as the commercial center for the Y-K Delta region and supports daily one hour flights to Anchorage. Aniak, on the Upper Kuskokwim River which has a Sub-Regional Clinic; and St. Mary's, on the Lower Yukon River also have regularly scheduled commercial flight services to Anchorage. Aniak serves as the upper port for ocean-going vessels on the Kuskokwim River during the summer.

Health care services for Y-K Delta residents are provided following a "Four Tier Model" which incorporates primary care services by: 1) Clinics, 2) Sub-Regional Clinics, 3) Yukon-Kuskokwim Delta Regional Hospital, and 4) Alaska Native Medical Center. The Four Tier Model is used to assure a continuum of quality care for patients needing advanced medical services.

Health care in the Y-K Delta is also provided through a variety of different organizations including YKHC, State of Alaska Public Health Nursing, Bethel Community Services, Infant Learning Program, Yukon-Kuskokwim Correctional Center clinic, and Bethel Family Clinic.

2. Other Local Agencies and Services:

Many federal and state agencies operate out of Bethel, including the U.S. Fish & Wildlife Service, Federal Aviation Administration, U.S. Postal Service, National Weather Service, U.S. Dept. of Agriculture, Alaska Dept. of Fish and Game, Alaska Dept. of Corrections, District Attorney's Office, Alaska State Troopers, Alaska National Guard, Alaska Dept. of Community and Regional Affairs, and a variety of other public service offices.

Some of the Native regional, non-profit organizations servicing the Y-K Delta include the Association of Village Council Presidents, Orutsararmiut Native Council, Kuskokwim Native Association, Association of Village Council Presidents Regional Housing Authority, Kuigpagmiut Inc., and the YKHC. Other places of employment consist of private retail shops, banks, seasonal construction, commercial fishing and fish-processing firms.

The communication system in Bethel and surrounding communities include telephone services that link "Bush" Alaska with the larger cities in the State. KYUK Radio/Television services broadcasts from Bethel, with substations in Chevak and Aniak. All Alaska communities, including those in the Y-K Delta, receive television programming via the Alaska Rural Communications Services (ARCS) by satellite from Bethel. The residents along the Kuskokwim River benefit from radio and television programming from KYUK and ARCS, while residents along the Lower Yukon River receive ARCS and radio services from KNOM and KICY radio in Nome, Alaska. KCUK radio operates out of Chevak, and rebroadcasts KYUK Radio signals to the coastal region of the Y-K Delta.

A weekly newspaper--The Tundra Drums--is based out of Bethel. For state and Daily news, Anchorage and Fairbanks newspapers are also available.

In the YKHC service area, K-12 education is provided by the Lower Kuskokwim, Lower Yukon, Kuspuk, Iditarod, Kashanamiut, and Yup'it School Districts. In October 1997, total enrollment for the school districts was 6,188 students.

The Lower Kuskokwim School District headquartered in Bethel, Alaska, is the sixth largest school district in Alaska. In higher education, the University of Alaska-Fairbanks operates the Kuskokwim Campus where a limited variety of Associate of Arts and Bachelor Degree programs are available, which are also provided through audio-conference classes all over the state. (Source: Alaska Department of Education, October 1, 1997.)

According to the Alaska Department of Labor in 1998, Bethel has experienced tremendous growth over the past two decades. The U.S. Bureau of Census and Alaska Department of Labor figures show Bethel's population in 1960 at 1,258; 1970 at 2,416; 1980 at 3,576; and 1990 at 4,674. The estimated 1997 population was 5,200. At the same time, the Alaska Department of Labor approximates that 68 percent of the population in Bethel is Yup'ik Eskimo. Local, state and federal employment accounts for 50.2 percent of the jobs in Bethel with private industry close at 49.8 percent of the full-time work force. Almost 30 percent of the population are high school graduates with an additional 10.5 percent having 1-4 years of college education. Many Bethel residents supplement their income with subsistence hunting, fishing and berry picking activities. Lack of water and sanitation infrastructure is a major public health and community development problem encountered throughout the Delta.

3. Environmental Factors

The subarctic climate of the Y-K Delta hosts short, cool summers and long, cold winters, which are affected by both the continental and transitional climatic zones. The continental zone is characteristic of warm summers and very cold, dry winters and includes the interior villages, depicting the largest land mass within the Y-K Delta. The transitional zone encompasses the coastal communities and exhibits generally milder temperatures than the interior with comparable precipitation levels (approximately 20 inches per year). High average wind speeds are present in both zones creating snowdrift barriers for ground transportation and high wind chill factors on cold days.

The geography and the climate of the Y-K Delta region poses severe transportation limitations. There are no existing road systems linking the 50 villages within the Yukon-Kuskokwim Health Corporation (YKHC) service area with the exception of a gravel road between St. Mary's, Pitka's Point and Mt. Village. The Kuskokwim and Yukon River systems and a network of lakes provide linkage between the villages by boat in summer and by snowmachine and truck/car or all terrain vehicle along the Rivers and their tributaries after freeze up.

4. Cultural Perspective

The YKHC service area's population is in transition from a traditional subsistence-based lifestyle to a blended subsistence and cash economy. This fundamental change is occurring rapidly and affects every facet of life in the Delta region including the growth of communities, population patterns, the environment, education, communications, transportation, and employment.

Both the Yup'ik and Athabascan cultures are centered around subsistence activities. Traditional values continue to stem from the relationship that the people have with the land and traditionally utilized resources. Native spirituality is rooted in the understanding and knowledge of how the people can maintain proper balance within their environment through efficient utilization of their resources (i.e., fish, game, birds and plants). Property

is largely related to the successful quest for and management of traditional natural resources. Traditional education emphasized the development of a personal awareness of the cycle of nature, having a reverence for subsistence resources and encouraged the widest possible distribution of resources for community benefit. These values bonded the social network of the community, strengthening cultural philosophies that promoted healthy family and kinship systems, and encouraged the sharing of food, working together and celebration of life.

Traditional values are so important that a museum in the early 1990s was constructed in Bethel, called the "Yup'it Piciryarait" (The ways of the Yup'ik peoples) Cultural Center to help preserve the traditions and lifestyles of the local indigenous peoples in the Y-K Delta region.

The population of the Y-K Delta is 89% Alaskan Native, primarily Yup'ik and Cup'ik Eskimo and Athabascan Indian. There are no highways between villages; rivers and trails must suffice for ground transportation. Many villages are more than 100 miles from the hospital. Village patients mostly come in by air taxi, or, in emergencies, by air ambulance (medivac). (Source: Where No Roads Lead, Making Your Way to Bush Alaska, YKHC, 1996).

Health and social service studies have commonly recognized that the continued high levels of alcoholism, suicide, and domestic violence are related directly to the rapid pace of social change within communities. Even though the American Indian, Eskimo, and Aleut population comprise only 15.58% of the general population in Alaska, the State Division of Alcoholism and Drug Abuse reported that of their 7,998 non-duplicated clients, 46% were Alaska Native. Since Western contact (50 to 75 years ago for the Y-K Delta region villages), contemporary values have been thrust upon the villages through western education, religion and government systems which conflict directly with traditional values and practices. Forced changes in lifestyle, economics, eating habits or food sources, family/gender roles and responsibilities have resulted in high stress levels. Stress associated with recent acculturation has contributed significantly to the overall poor health status of Alaska Native peoples.

5. Demographics

The Yukon-Kuskokwim Health Corporation serves a population of 22,735 persons living in parts of three census areas. The census area includes all of Wade Hampton, Bethel (excluding Goodnews Bay, Platinum, Cape Newenham and Sparrevohn Station), and four villages in the Yukon-Koyukuk census area (Grayling, Anvik, Holy Cross and Shageluk). Excluding Bethel, approximately 94% of the population is Native Alaskan (Yup'ik and Cup'ik Eskimo, and Athabascan Indian). Of the 50 service villages, 44 have a Yup'ik or Cup'ik majority, 5 have an Athabascan majority, and 1 village has a high percentage of non-Natives. The high non-Native population (37%) is concentrated primarily in the City of Bethel. Bethel is the only Level III Regional Center. There are four communities designated as Level II Sub-Regional Centers (Mountain Village and St. Mary's are counted together). The remaining 44 are designated as Level I Villages. (Source: Alaska Area Native Health Service, 1998.)

The Native population in the Delta has increased by 55% in the past 20 years. A 1987 study, conducted by Gary Zaret, MD, estimated that at current birth rates, the Delta population will double in the next 30 years. The Y-K Delta population is extremely young. Infants and children, from birth to 10 years

of age comprise 27% of the total population. Excluding Bethel, 48% of the total population is under 20 years of age. Less than 5% of the total population is 65 years of age or older. The median age, which is gradually increasing, is 23.5 years of age. (These figures are based upon 1991 estimates from the Alaska Department of Labor, Research and Analysis on the figures provided to them by the U.S. Department of Commerce, Bureau of the Census.)

Of the entire Alaska population, according to the Alaska Department of Labor Estimate, Alaska's population was 611,300 in July 1, 1997, with median age of 32.4. The largest population in Alaska is White, numbering 453,690 in 1997, or 74.25 percent, with median age of 34.4. The Alaskan Native population in the same period was 101,904 or 16.67 percent of the total population, with median age of 23.2. The Alaskan Native is Indian, Eskimo, or Aleut. The 9.08 percent, or 55,506 remaining represents other. The Eskimo group is made up of Yup'iks and Inupiaqs (the Yup'ik has other sub-groups, such as the Cup'iks). The Eskimos are the largest population of Alaska's indigenous people. 317 Alaskan communities were counted in the 1990 Census. 55% or 173 of these communities have more than a 50% majority of American Indian, Eskimo and/or Aleut population (50 of these communities are within the YKHC service area). Communities having a Native Alaskan majority and a population of more than 1,000 are Barrow, Bethel, Dillingham, Kotzebue, Metlakatla, and Nome. The Y-K Delta is home to the world's largest concentration of indigenous Eskimo people.

6. Education

The best method to show education results for YKHC region school is to compare it with other Alaska Rural School Districts. Comparisons below are taken from 1996-1997 Alaska District Profiles* for the 11th Grade California Achievement Tests version 5 scores (CAT5) taken by all Alaska Students in 1997. Numbers represent top and bottom quartiles for reading, math, and languages.

School District	Student #	TQR	BQR	TQM	BQM	TQL	BQL
Lower Kuskokwim	3,372	4.8	69.0	14.7	40.0	7.4	48.0
Bristol Bay	313	25.0	25.0	25.0	15.0	20.0	15.0
Kashunamit	247	8.3	83.3	16.7	25.0	0.0	25.0
Lower Yukon	1,736	0.0	62.7	2.0	49.0	3.9	43.1
North Slope	1,937	3.2	67.7	7.8	43.8	0.0	58.7
St. Mary's	130	0.0	85.7	0.0	71.4	0.0	42.9
Southwest Region	701	0.0	79.2	28.0	40.0	0.0	41.7
Yup'it	401	0.0	100.0	0.0	80.0	0.0	93.3
Alaska Statewide	126,465	29.6	22.7	33.5	18.6	24.1	23.3

TQR - Top Quartile Reading BQR - Bottom Quartile Reading

TQM - Top Quartile Math BQM - Bottom Quartile Math

TQL - top Quartile Language BQL - Bottom Quartile Language

*Source: Report Card to the Public, Alaska Department of Education, 1998

7. Economic Condition

The socioeconomic status for this region is also lower relative to the rest of Alaska. Of those persons over 25 years of age, less than 56% are in the labor force. Unemployment often exceeds 80-90% in Y-K Delta villages. More

than 40% of the region's families have incomes below the Federal Poverty Line (figure A). This compares to the statewide figure of 12%, and ranks the highest in Alaska. The household median income in the Y-K Delta, \$20,524, is less than one-half that of the state average of \$41,408 (figure B). Y-K Delta per capita income is \$7,121, compared with the State of Alaska per capita income of \$17,610. In addition to having less income than other Alaskans, families living in this area must contend with a higher cost of living, spending 52% more per week on food, 165% more on electricity and 46% more on a barrel of heating oil than does a family of 4 living in Anchorage. [Source: The APN Report of the Status of Alaska Natives, A Call For Action, 1988.]

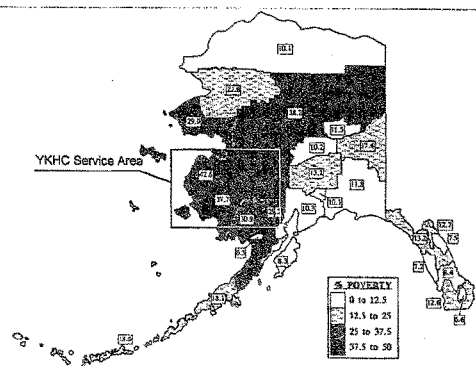


FIGURE A - PERCENT OF PERSONS IN POVERTY: (Source: Alaska Area Profile, 1997)

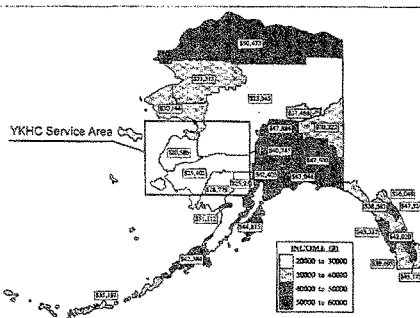


FIGURE B- MEDIAN HOUSEHOLD INCOME: (Source: Alaska Area Profile, 1997)

8. Health Status in the Y-K Delta

Indicators of the health status of the Y-K Delta population reflect high infant mortality, premature death in adolescents and young adults due to injuries (both intentional and unintentional), pervasive chemical misuse, and a high prevalence of infectious and respiratory diseases. Although much progress has been made to improve the health status of Y-K Delta residents through various interventions, the population continues to suffer some of the highest morbidity and mortality rates in the United States, as the following statistics indicate:

Birth Rate: The three-year infant births rate in 1994 for the Yukon-Kuskokwim Delta Service Unit stood at 33.1 per 1,000 total native population. The U.S. rate for the same period was 15.2. (Source: HIS Report NSU-01 dated April 25, 1996. National rates are from National Center for Health Statistics.)

Teen Pregnancy: Throughout the 1990s Alaskan Native Teenagers were having babies at rates that rivaled and often surpassed rates in non-industrialized nations. Early indications are that teen pregnancy rates have been decreasing in the Y-K Delta the past three years, primarily due to improved access to contraception and health education. (IBID.)

Infant Mortality: Infant mortality rates in the Y-K Delta remain high. Infant death rate for the same period stood at 10.8 per 1000, while U.S. rate stood at 8.0. The neonatal rate stood at 3.8, and postneonatal rate at 5.9 against U.S. rate of 2.9 per 1000. (IBID.)

Mortality: The Three Year (1993-95) Average Crude Mortality Rate for the Yukon-Kuskokwim Delta Service Unit indicates that the total Alaska Natives deaths is 572.3 per 100,000. Even though this is lower than the U.S. rate, deaths due to accidents, suicide, homicide and alcohol-related causes (includes alcoholic psychoses, alcohol dependence syndrome, non-dependent alcohol abuse, and alcoholic cirrhosis) are many times higher than the national average.

Suicide: Over the three-year period, 1993-95, the crude death rate for the Yukon-Kuskokwim Delta was 48 per 100,000. For the same period, Kotzebue and Norton Sound areas showed highest suicide rate. Mt. Edgecumbe area showed the lowest. Crude suicide rates for Alaska Native total showed an increase by 46.5 for the same period. This category includes suicide and self-inflicted poisoning by solid or liquid substances, gases and vapors, hanging, strangulation, and suffocation, submersion, firearms and explosives, cutting and piercing instruments, and self-inflicted injury. (Source: Alaska Area Native Health Service, Div. Of Planning, Evaluation, and Health Planning, July 1997.)

Alcohol: The crude death rate for the Yukon-Kuskokwim Delta was 35 per 100,000 between 1993-95. For the same period, Barrow, and Norton Sound crude death rates showed higher. The crude death rate for Alaska Native total showed an increase by 38.8 per 100,000. (IBID.)

Alcohol-related morbidity is reflected most typically in injury prevalence. Although overall numbers of persons seeking medical treatment for injuries at the Yukon-Kuskokwim Delta Regional Hospital in Bethel has been declining in recent years, the proportion of persons seeking medical treatment for alcohol-related injuries is increasing. Physicians at the hospital have

observed (information obtained from The Calista Region: "A Gentle People, A Harsh Life," February, 1989) that:

- Eighty to ninety percent of all injury cases are alcohol-related;
- Two-thirds of all major frostbite cases are alcohol-related;
- Many children's injuries are caused by alcohol-related parental unawareness or neglect;
- Fetal alcohol syndrome is seen on a regular basis in babies born to mothers who are village residents; and
- Alcohol used by pregnant women affects the high infant mortality rate.

Alcohol use is also a factor in the high rates of domestic violence, sexual assaults, and child abuse. These have been widely reported in the Anchorage Daily News series, "A People in Peril" and The AFN Report on the Status of Alaska Natives: A Call for Action, 1988.

The statistics gathered by the Division of Family and Youth Services and the Tundra Women's Coalition indicate high numbers of intakes and crisis intervention-most of them alcohol-related. In Bethel, the police department estimates that 90% of the arrests are also alcohol-related.

Accidents: The crude death rate for the Yukon-Kuskokwim Delta for the period between 1993-95 stood at 110 per 100,000. Kotzebue and Bristol Bay showed higher rates, while Mt. Edgecumbe area received the lowest accidental rate. The overall accident crude death rate for Alaska Natives (Alaska Total) for the same period stood at 108, slightly below the Yukon-Kuskokwim rate. This category includes such incidents as railway, motor vehicle traffic and non-traffic, water, air, and space transport, accidental poisoning by drugs and gases, surgical and medical procedures, accidental falls, accidents caused by fire and flames, and natural and environmental factors, and accidents caused by submersion, suffocation, and foreign bodies. (Source: Alaska Area Native Health Service, 1997)

In addition to the outpatient services provided by the Hospital, health services are provided in 48 village clinics staffed by the Community Health Aides. The Yukon-Kuskokwim Health Corporation Workload Summary for fiscal year 1997 indicates that Y-K Delta clinics had 105,818 individual patient encounters, an increase of 5.3% over 1996 figure of 100,207. (Source: YKHC-Community Health Aide Program Patient Encounters, 1996, 1997.)

Ten leading causes of visits at the Yukon-Kuskokwim Delta Regional Hospital in Bethel for all ages were:

Causes	FY'93	FY'94	FY'95
1. Upper Respiratory Problems	5,454	7,649	7,614
2. Refractive Error	7,206	3,688	6,429
3. Hypertension	3,298	5,384	6,037
4. Otitis Media	4,587	5,170	5,363
5. Prenatal Care	5,116	7,074	5,099
6. Accidents & Injuries	3,117	4,762	4,926
7. Tests Only	3,122	2,004	4,588
8. Family Planning	2,747	3,337	3,212
9. Immunization	2,558	1,154	2,813
10. Bone & Joint Disorders	1,493	2,332	2,739

Source: Alaska Area Native Health Service, Division of Planning, 1997

Cases of specific diseases for two census tracts, Wade Hampton and Bethel, for a 10 year period (January 1, 1988 through December 31, 1997) reported to the Alaska Division of Public Health are as follows:

Disease	Wade Hampton	Bethel	Total
Tuberculosis	44	52	96
Hepatitis A	333	455	788
Gonorrhea	169	998	1164
Chlamydia*	76	320	396
Enteric Pathogens+	7	28	35
Botulism, foodborne	9	32	41

*reportable since January 1996

+campylobacter, giardia, salmonella and shigella

Source: State of Alaska, Dept. of Health & Social Services, Division of Public Health, Section of Epidemiology, 1998

AIDS Cases through June 30, 1998 (Total since 1982, start of epidemic)

Wade Hampton:	2
Bethel:	5
(Source: IBID)	

Yukon-Kuskokwim Delta Regional Hospital Patient Visit Statistics from 1995 to 1997.

Service Category	1995	1996	1997
Ambulatory	88,664	65,758	98,010
Inpatient	2,249	2,036	2,200
Telecommunications	6,148	4,911	3,651
Chart Review	724	355	753
Day Surgery			411
Total	97,785	73,060	105,778

Note: (In FY97 there were a total of 7,279 incomplete patient care encounter forms due to inadequate documentation. These forms did not get entered into

PCC) Source: Yukon-Kuskokwim Delta Regional Hospital, Health Information Service, 1998.



YUKON-KUSKOKWIM HEALTH CORPORATION

"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion."

February 17, 1999

House Committee on Resources

Attn: Hon. Representative Don Young, Chairman
The U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Young and other dignified members of the House Resources Committee,

The Board of Directors of the Yukon-Kuskokwim Health Corporation (YKHC) are grateful for the invitation by the Committee on Resources for our President & CEO, Mr. Gene Peltola, to speak on the behalf of our organization.

We are deeply regretful that Mr. Peltola is unable to present his testimony before your committee. Therefore, this letter authorizes Orie Williams, Executive Vice President for YKHC to make testimony on Gene Peltola's behalf and on behalf of our member-beneficiary Tribes, concerning CSC within the Indian Health Service Annual Budget.

We are happy to announce that 1999 marks the 30th year in which YKHC has contracted Indian Health Service programs. In addition, since 1991, YKHC has also operated the Yukon-Kuskokwim Delta Regional Hospital (YKDRH) in Bethel, Alaska.

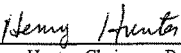
We offer our sincere gratitude for the opportunity to provide testimony before the House Committee on Resources. We hope to accomplish what is necessary to continue improving the health of the Alaska Natives and the American Indian Tribes within the United States.

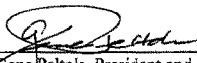
We extend an invitation to the House Members and their staff to visit us in Alaska and the Yukon-Kuskokwim Delta region. We would like to share with you the sights of our great state and the boundless and unmatched hospitality of our people.

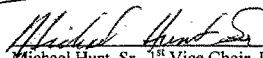
Hon. Congressman Don Young
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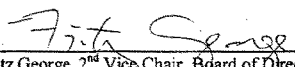
Most Sincerely,

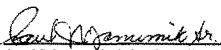
**THE YUKON-KUSKOKWIM HEALTH
CORPORATION**

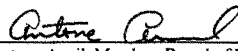

Henry Hunter, Chairman, Board of Directors

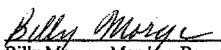

Gene Peltola, President and CEO


Michael Hunt, Sr., 1st Vice Chair, Board of
Directors


Fritz George, 2nd Vice Chair, Board of Directors



Paul Manumik, Member, Board of Director

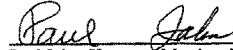

Antone Anvil, Member, Board of Directors


Billy Morgan, Member, Board of Directors


Robert Enoch, Member, Board of Directors

Hon. Congressman Don Young
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James Charlie, Sr., Member, Board of Directors


Paul John, Honorary Member, Board of
Directors

STATEMENT OF LIEUTENANT GOVERNOR CECIL ANTONE, GILA RIVER INDIAN
COMMUNITY

INTRODUCTION

Good morning, Mr. Chairman and Members of the Committee. My name is Cecil Antone and I am the Lieutenant Governor of the Gila River Indian Community. I have had the privilege of serving as Lieutenant Governor since I was first elected in 1993. I am honored to have the opportunity today to represent the Gila River Indian Community before the Committee to discuss Federal funding for contract support costs associated with health care programs in Indian Country ("Contract Support Costs"). This is an issue of vital importance to the health and welfare of our Community members, as well as members of the Nation's other Indian tribes.

The Gila River Indian Community (the "Community") is located on 372,000 acres in south central Arizona. Our Community is composed of approximately 19,000 tribal members, 13,000 of whom live within the boundaries of the Reservation. We have a young and rapidly growing population that presents us with a variety of health care challenges, now and in the future.

It is appropriate that the Committee has asked the Community to testify at today's hearing. Although our Community's experience with Contract Support Cost funding exposes some of the weaknesses of past funding practices, it also illustrates the significant rewards that can result when Indian tribal governments embrace the self-determination policy articulated in the Indian Self-Determination and Educational Assistance Act ("ISDEA") by taking over operation of health care programs. We believe our story has both lessons to teach and hope to give in reaching a lasting solution to the Contract Support Cost funding issue.

We have attempted in this testimony to provide the Committee with our views with respect to the questions it has posed to the Indian Health Service ("IHS") about Contract Support Costs. We have tried to answer those questions in the context of the story we have to tell about our experience with Contract Support Cost funding.

THE CONTRACT SUPPORT COST ISSUE

I would like to take the opportunity to briefly present some background on the role of Contract Support Cost funding in the successful implementation of self-determination policy. Our Community believes strongly that anything less than full and recurring funding of Contract Support Costs compromises the fundamental purposes underlying the Federal policy of tribal self-determination. We believe that Congress and the Administration understand this, as well. More than a decade ago, the United States Inspector General concluded that the Federal Government's payment of Indian tribal governments' Contract Support Costs enables Indian tribal governments to improve their administrative capacity and comply with Federal requirements applicable to the operation of their health care programs.¹ The Committee Report that accompanied the 1988 amendments to ISDEA went on to state as follows:

The use of indirect costs is widely accepted by state, county and local governments, and by universities, hospitals and nonprofit organizations. The most relevant issue is the need to fully fund indirect costs associated with self-determination contracts. The [Administration] should request the full amount of funds from the Congress that are adequate to fully fund tribal indirect costs. Furthermore, the Bureau of Indian Affairs and the Indian Health Service must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services.²

Contract Support Cost funding is absolutely crucial to the ability of Indian tribal governments to operate health care programs transferred to them by IHS because those funds cover the "overhead" and other administrative costs that Indian tribal governments incur in operating contracted Federal programs. Examples of such costs include personnel, audit, financial and property management services.

In some cases, full funding for these functions cannot be transferred from the IHS to Indian tribal governments because the function is provided by a Federal agency outside the IHS. For example, the Department of Justice and the Department of Health and Human Services Office of General Counsel provide IHS with legal services, the Office of Personnel Management provides IHS with personnel support and training, and the Office of Management and Budget provides IHS with budget and program policy formulation and analysis.

¹ S. Rep. 100-274 at 11.

² *Id.* at 11-12.

In other cases, IHS cannot transfer full funding for such functions because the costs are not incurred by IHS at all, but Indian tribal governments must incur the cost to operate the program. Examples of such costs include liability insurance and audit costs. When the IHS cannot directly transfer necessary resources to Indian tribal governments to support a function required by contracts with IHS, IHS is required by ISDEA to provide the Indian tribal government with Contract Support Cost funds to cover these costs.

As the Committee is aware, there is a long history of inadequate funding of Indian tribal governments' Contract Support Costs. Congress made specific amendments to ISDEA in 1988 and 1994 to remedy this problem by requiring the IHS to add to the amount available for direct program costs the full amount of Indian tribal governments' Contract Support Cost need. Nonetheless, inadequate appropriations have remained a significant obstacle to realizing the self-determination mandate. The sad result is that every un-funded dollar of Contract Support Costs must be compensated for by Indian tribal governments by reducing their level of effort to maintain administrative systems or by reallocating funds for patient services to pay administrative costs—a result ISDEA and its amendments specifically sought to avoid. In the present environment of inadequate funding for Indian Health Services, funding for tribal health services cannot be further diverted without having a severe impact on health care status.

The \$35 million that was appropriated for Contract Support Costs in Fiscal Year 1999 was a significant accomplishment, but we must continue our work to find a reasonable, lasting solution that recognizes the validity and necessity of full and recurring Contract Support Cost funding to the realization of the goals of tribal self-determination. Any such solution must acknowledge that increases in Contract Support Cost funding are imperative and unavoidable if the true promise of the self-determination policy is to be realized.

THE SUCCESS OF TRIBAL HEALTH CARE PROGRAMS AND SERVICES

I would like to turn now to the success of the policy of Indian self-determination. Tribal leaders have testified consistently throughout the years to the importance of the self-determination policy in building local programs and administrative infrastructure. In oversight hearings conducted in the Spring of 1987, for example, tribal leaders testified that through self-determination, Indian tribal governments experienced greater utilization of services, increased stability in tribal government and communities, and a greater focus on tribal economic development. Our Community's experience has been the same.

Since the Community assumed local operation and management of health care services through our Department of Public Health and the Gila River Health Care Corporation ("the Corporation"), our Community has expanded and improved services in many ways. For example, we have restored services that IHS was forced to eliminate due to inadequate funding in the early 90's and we have changed aspects of health care delivery to be more responsive to Community members.

These changes have resulted in increased outpatient visits and a redirection of services to target our Community's most serious health needs. We have made these improvements despite operating the largest component of our health care system—the Corporation—for three (3) years with no Contract Support Cost funding and our Department of Public Health at less than full funding. The Corporation alone has absorbed between \$2 and \$3 million in un-funded costs in each of the last three years.

The program funding we "lost" as a result of having to absorb Contract Support Costs was requested and appropriated by Congress to be used to provide health care services to our Community. Moreover, it is important to remember that the IHS program funding that is made available to Indian tribal governments is 2/3 less than the average U.S. per capita expenditure for health care services for the rest of the Nation. Indian tribal governments are forced to stretch already limited health program dollars even farther when Contract Support Costs are not covered by adequate appropriations.

Our Community, fortunately, has been able to keep the level of health care service constant due to the increased control its exercises over program dollars. This control was formerly in the hands of the IRS bureaucracy. We have also increased our third party collections and received some funds from other Community sources to support increased health care services to our members. However, even after re-investing these additional resources into our program, our total funding provides approximately \$1,400 per patient—well below the national average of \$3,046 per patient. Thus, although our Community has achieved far greater efficiencies than the IHS in utilizing scarce Federal resources, the fact remains that under-funding Contract Support Costs requires our Community to use funds appropriated for services for

administrative costs that are not only legitimate and reasonable, but legally required by our contracts with IHS.

Despite operating under less than ideal conditions, we believe we have made impressive strides in improving health care services, which indicates to us the promise inherent in the policy of self-determination. For example, our Community, like many other tribal communities, is facing the challenge of a serious diabetes epidemic. The social cost of diabetes in our Community is staggering. The incidence of type 2 diabetes exceeds 50 percent in our adult population, with an additional 10 percent of our members having impaired glucose tolerance. Our children are not immune from this epidemic—over 70 children under age 18 have full-blown type 2 diabetes, which, prior to 1998, was rarely reported in the medical literature in children of this age group.

Among the many serious complications of diabetes is gangrene of the limbs, which often results in amputations. In 1988, with no podiatrist on the staff of the IHS hospital, there were twenty (20) lower extremity amputations in our Community. In the last few years, with two full-time podiatrists and a residency program in podiatry we have reduced the number of amputations to between three and five per year. While this is a significant improvement, our podiatrists need improved and immediate access to surgical facilities to further reduce and hopefully eliminate lower extremity amputations in our population.

Gum disease is another diabetes-related condition, which if left untreated can result in complete tooth loss. Our Community's dental program now provides enhanced periodontal care for patients with diabetes. Our diabetes patients are given immediate access to appointments for examination and diagnosis and are treated utilizing a specialized protocol developed at our facility. Treating patients with this protocol has produced improvements in diabetes management as measured by glycosolates hemoglobin levels.

With over 3,000 individuals in our diabetes registry, the cost of providing care continues to increase. Almost 150 of our patients are on dialysis, awaiting renal transplantation. Pharmacy costs also continue to increase at a rate that exceeds 18 percent per year as newer agents (such as troglitazone) are necessary to improve the management of diabetes and forestall the progression of microvascular disease and its effect on the kidney, heart, eye, and peripheral vascular systems.

In an effort to combat the severe diabetes epidemic within our population, the Community is currently pursuing a multi-disciplinary Center for Excellence for culturally appropriate approaches to the prevention of diabetes. Our Community would support special assistance by Congress to Indian tribal governments contemplating such initiatives to target the most severe health care problems plaguing Indian populations as an incentive for further health care improvements within tribal health care programs.

In addition, the limited Contract Support Cost dollars that our Department of Public Health has been receiving through its separate contracts with IHS have helped to build our health care delivery infrastructure. These Contract Support Cost funds, although funded at much less than 100 percent of need, have helped us create an additional executive position to further improve the management of the numerous health care programs within the Department. In addition, our Alcohol and Drug Abuse Program has been able to hire additional counselors. Other public health programs within the Community have also been able to increase services for the benefit of the Community, such as through hiring additional staff.

We are beginning to convert the Department of Public Health from an underfunded and overworked tribal health care agency into a public health agency that we believe can rival the best local and state programs. So far, we have measured the improvements in Department of Health programs in small steps, and there remains a long way to go. In October 1998, we began to examine the infrastructure that was needed by our Community to develop and maintain the necessary databases to monitor the public health status of Community members. This type of tribal-specific health information is not kept by national databases and is essential to monitoring long-term health statistics of our Community members. We are also developing an Intergovernmental Agreement between the Community and the State of Arizona dealing with areas of mutual concern and cooperation on areas of health. In this respect, the Department of Public Health, through its self-determination efforts, has already greatly exceeded the prior efforts of IHS.

Perhaps most importantly, since taking over operation of certain health care programs, the Department of Public Health has been able to locate essential services, such as Well Child Clinics, a Wellness Center, Alcohol and Drug Abuse Program Counseling, Public Health Nurses, Community Health Representatives, and emergency medical vehicles, at accessible locations throughout our Community. These Community-based services were not even contemplated by the IHS.

These tremendous strides in health care service improvements by our Community have been made at the same time that significant cost savings have been achieved through the assumption of local operation of administrative functions. Examples include the ability to enter into contracts directly with outside service providers, typically at reduced rates based on our ability to pay invoices on time, and to hire needed personnel directly rather than going through the MS Area Office Federal personnel system, under which we had to wait an excessively long time and often accept less than ideal candidates.

THE COMMUNITY'S EXPERIENCE WITH CONTRACT SUPPORT COST FUNDING

I would now like to discuss in more detail the Community's experience with the under-funding of Contract Support Costs during the last three (3) years to highlight some of the problems we have encountered. In June of 1995, as the Community was preparing to contract with IHS to assume operation and management of the Community's Hospital, our Community submitted a Contract Support Cost request of \$4 million.

Because of the IHS practice of utilizing a "queue," or waiting list, for unfunded self-determination Contract Support Cost requests, our request was placed on the Indian Self-Determination queue ("ISD queue") and we waited for funding. Each year we did not receive funding and but continued to track and refine our Contract Support Cost request. Eventually, our requests made it close to the "top" of the ISD queue and we would have been funded at 100 percent in Fiscal Year 1999 if the ISD queue system had continued as it was operated in the past.

However, despite a backlog estimated at over \$60 million in unfunded Contract Support Cost requests, the Administration requested no new funds for the ISD queue in Fiscal Year 1999. After a massive effort by Indian tribal governments and tribal supporters in Congress, \$35 million in new funding was included in the Fiscal Year 1999 IHS appropriation. We understand that this will allow both our Department of Public Health and Health Care Corporation to receive approximately 70 percent of our Fiscal Year 1999 request.

Although we will not receive our anticipated 100 percent Contract Support Cost funding in Fiscal Year 1999, we support the proposed method of allocating the \$35 million in new funding because we believe it goes along way toward bringing all Indian tribal governments closer to meeting their Contract Support Cost need. However, under the proposed allocation methodology, another \$1.2 million of our IHS-approved Contract Support Costs will not be funded in Fiscal Year 1999. This brings our total unfunded Contract Support Costs over the last four (4) years to between \$8 and \$11 million.

While Section 314 of the Fiscal Year 1999 IHS appropriations bill expresses the view that Indian tribal governments should not be able to collect these past due amounts, we believe this view simply invites needless litigation and would be better addressed jointly by Congress, the Administration, and Indian tribal governments discussing this issue to reach some consensus on how to address this past liability. In this regard, we need a firm commitment from Congress and the Administration that they will continue to strive to address our past unfunded costs and to reach and maintain 100 percent funding for the future.

THE NEED FOR ACCURATE CONTRACT SUPPORT COST DATA

If Congress is to commit to reaching and maintaining 100 percent Contract Support Cost funding, they obviously need more accurate Contract Support Cost estimates for appropriations purposes. With respect to that issue, I would now like to discuss the Committee's concern about the lack of accurate and complete data relating to current and projected future Contract Support Costs during the last appropriations period.

As Committee Members are aware, during the Fiscal Year 1999 appropriations period, there was much discussion about how the \$35 million in new funding would be allocated among the Indian tribal governments. That complex debate was made significantly more difficult due to the lack of firm Contract Support Cost numbers from IHS.

We believe the past practice of maintaining a queue and expecting that only the top \$7.5 million in requests would be funded each year very likely contributed to the lack of accurate information concerning the real Contract Support Cost need for all Indian tribal governments contracting with IHS. IHS apparently did not feel compelled to scrutinize and finalize queue requests until an Indian tribal government was nearing the top of the queue. The Contract Support Cost debate during the Fiscal Year 1999 appropriations cycle required accurate numbers for all Indian

tribal governments on the queue and highlighted the importance of accurate and thorough information.

IHS, and particularly the Office of Tribal Programs and Finance staff, should be commended for their efforts in the past six (6) months toward getting a handle on current Contract Support Cost needs and projecting the additional funds needed to remedy the remaining shortfalls. Now that a significant portion of the hard work has been done, it is critical that IHS Headquarters work with the Area Office staff to keep the information updated and accurate and to work more closely with Indian tribal governments to get their future Contract Support Cost needs sufficiently in advance.

REDUCTIONS IN IHS

With respect to the Committee's inquiries concerning the feasibility of further reductions in IHS bureaucracy, we do not believe it is necessarily possible for IHS to make parallel reductions in the IHS with each self-determination contract it enters. We would, however, like to see a dynamic change in the function, direction, and organization of the agency as more Indian tribal governments provide their own health care services. For example, in the Phoenix Area, many Indian tribal governments, unlike our Community, operate their public health programs and IHS provides the direct care.

Under the present system, these Indian tribal governments continue to need the support of an Area Office focused on the provision of direct care. At the same time, our Community no longer needs or utilizes these IHS program support functions, and where we do need such support, we generally hire appropriate personnel or contract with consultants who have the required private-sector expertise.

To support our programs, we need the IHS to work with us in a true government-to-government partnership to timely and cooperatively provide us with information pertinent to our Federal funding for which it is the conduit. There should be some corresponding reduction of effort within the IHS resulting from the change in services and functions that are provided by an Indian tribal government under a self-determination contract. We support Federal legislation that would provide a reduction in IHS administration, consistent with the goals of ISDEA policies, so long as the diverse and unique needs of all Indian tribal governments are considered in any such plan.

We also acknowledge that significant barriers to downsizing IHS exist. For example, any legislation mandating reductions will have to take into account Federal employment laws and how they affect the agency taking reductions commensurate with the functions that have been contracted.

As a related matter, we strongly support legislation to make self-determination permanent within the IHS, given the demonstrated success of the self-determination policy. Such legislation would be similar to H.R. 1833, co-sponsored by Chairman Young and passed by the House in the 105th Congress, which would have permanently established and implemented tribal self-governance within the Department of Health and Human Services.

ACHIEVING THE HIGHEST LEVEL OF HEALTH CARE

Aside from reducing or reorganizing IHS, we have other suggestions as to how to achieve the highest level of tribal health care possible. For example, we believe that higher levels of health care would result from more consistent and reasonable application by IHS of the rules governing what is included in the indirect cost pool for determining indirect cost rates for Indian tribal governments. Currently, an unintended penalty is imposed on certain Indian tribal governments by the large differences in indirect cost rates negotiated by the Inspector General.

Indian tribal governments like ours with lower indirect cost rates, often due to economies of scale, receive proportionately less of the available Contract Support Cost dollars as a result. The effect is that the most efficient Indian tribal governments receive a proportionately smaller portion of available Contract Support Cost dollars. Our Community has, comparatively, a very low indirect cost rate of about 13 percent, compared to rates close to 100 percent for other Indian tribal governments. Therefore, we would support efforts by IHS to apply a more consistent and reasonable methodology to the determination of costs included in the indirect cost pool, recognizing of course the diverse needs of Indian tribal governments.

With respect to the Committee's request for suggestions for the removal of barriers to efficient health care delivery by Indian tribal governments in order to achieve the highest level of tribal health care, our Community would support agency assistance for Indian tribal governments in accessing other Federal programs that can bring in additional funds, such as those within the Centers for Disease Control and Prevention and the Office of Minority Health.

We also have some ideas in response to the Committee's request for suggestions to increase flexibility in the administration of local health care programs. Our Community's health care programs would benefit, for example, from access to the Federal Health Care Professions Fund, from which the agency currently excludes Indian tribal governments from participation. Access to the Fund would allow Indian tribal governments to identify and recruit candidates from the tribe to send to medical or business school to assume medical or executive positions within the operation of the local health care programs. The recruitment of tribal members for long-term employment within tribal health care operations is a proven way to ensure the long-term stability of tribal health care programs. In addition, currently the IHS's Prime Vendor Program requires the Corporation to purchase drugs through IHS. The Community's ability to purchase drugs on its own would result in increased cost savings and efficiency.

Although we do not have the opportunity to fully develop these and other ideas in this testimony, they may be worth exploring further in another context in an effort to further improve the efficient delivery of tribal health care services.

HEALTH CARE DELIVERY ALTERNATIVES

With regard to Indian tribal governments that strive for the highest health care possible but choose not to contract with IHS for local operation of health care programs, we believe it would be helpful if non-contracting Indian tribal governments had more authority to tell IHS what programs they would like to see IHS put in place to meet the specific health care needs of tribal members. Other mechanisms, such as meaningful tribal participation on IHS service unit governing boards, would assist in improving care and meeting the needs of tribal communities where a tribe does not choose to contract directly.

It is important not to lose sight of the fact, however, that new approaches to the delivery of health care cannot replace the urgent need for increases in Contract Support Cost and program funding. What Indian tribal governments need now before anything else is a firm commitment from the Administration and Congress new funds will be made available on a recurring basis to meet existing needs. Even among Indian tribal governments with dramatic records of health care improvement, there is much more to be done and much more could have been done had the Indian tribal governments received the full 100 percent Contract Support Cost funding to which they are entitled. The first priority, then, should be to add to the IHS budget to give Indian tribal governments 100 percent of their Contract Support Cost and program needs so that necessary improvements in services can be made.

MORATORIUM

Finally, in addition to ensuring full and recurring Contract Support Cost funding for Indian tribal governments that currently have operating programs, it is vital to the policy of self-determination that Indian tribal governments have the continued right to enter into self-determination contracts in order to take over administration of health care programs and services. That is why we fully support lifting the 638 contract moratorium applied by Congress this past year on any new and expanded 638 contracts. The moratorium is a direct affront to the right of self-governance and self-determination provided to Indian tribal governments under ISDEA and is not a long-term solution to Contract Support Cost funding issues.

CONCLUSION

These are just a few of the examples we can offer of the promise that tribal administration of health programs holds for improving the health and welfare of Indian people throughout the Nation. In order for the full promise of ISDEA to be realized, however, Congress must commit to a plan to increase funding for Contract Support Costs to an extent that will allow full and recurring funding for Contract Support Costs in future years.

The Gila River Indian Community believes strongly that the Administration, Congress, and Indian tribal governments working together can find a way to improve the mechanism for providing needed Contract Support Cost funding to Indian tribal governments. The reward will be increases in health care improvement and efficiencies in the operation of tribal health care programs throughout the Nation.

The first priority must be increasing the funding available to Indian tribal governments for Contract Support Costs to reach the goal of full and recurring Contract Support Cost funding. To that end, we seek a firm commitment from Congress that it will seek an increase in the money available to Indian tribal governments to cover Contracts Support Costs now and in the future.

We appreciate that IHS has made significant progress in addressing these issues in recent months. We encourage Congress, however, to remain committed to increasing Contract Support Costs not only within the IHS budget, but also within the Bu-

reau of Indian Affairs budget. In addition, any proposed congressional solution to Contract Support Costs should address in a consistent manner Contract Support Costs within the IHS and the BIA, as well as any other Federal agency that impacts Indian programs.

What our story and that of other Indian tribal governments demonstrates is that tribal contractors will do best when they are given the funding they need and work in a true government-to-government relationship to create solutions to their unique health care challenges. Indian tribal governments have proven that the self-governance framework can build tribal administrative capacity, reduce bureaucracy, save money, and, most importantly, improve the quality of health care services to tribal members. It is now up to all of us to find a lasting solution to Contract Support Cost funding that honors the Nation's commitment to Indian tribal governments.

**Statement of Kevin Gover, Assistant Secretary-Indian Affairs, Department of the Interior,
at the Hearing Before the United States House of Representatives, Committee on Resources
on the Impact to the Bureau of Indian Affairs due to increased Indian Tribal
Contracting/Compacting and on Contract Support Costs**

February 24, 1999

Mr. Chairman and members of the Committee, I am pleased to present the Bureau of Indian Affairs' (Bureau) testimony on Contract Support Costs and the impacts of past and current funding associated with contracting under Public Law 93-638, the Indian Self-Determination and Education Assistance Act.

As this Committee knows, the funding of contract support costs is a long standing issue that recently has been further exacerbated by a federal court decision mandating the Bureau to develop an alternative way to project and fund contract support costs. The Committee itself is interested in learning how the Bureau will project future contract support costs.

Let me begin with a brief summary of what I believe are the reasons the Bureau has been unable to accurately project funding needs which resulted in funding shortfalls. While there are several variables that have contributed to the difficulty of projecting accurate information, we believe that annual appropriations have been unable to keep up with the growth in contracting. Additionally, the statutory or administrative caps imposed by other federal agencies on payment of their share of tribal indirect costs have contributed to this, as well. In addition, the calculation of indirect cost rates is a dynamic process that is constantly changing. The decision to contract a Bureau program, rests solely with tribes. Once the decision is made tribes are required to provide the Bureau with only 90 days notice of their intent to contract. This makes it somewhat difficult to predict with any degree of accuracy the level of contracting or compacting that will take place in the future. Initially, proposals are based on projected or expected direct federal funding; there are no guaranteed or fixed amounts of annual funding. There is no single type of rate or method used although the most common is a Fixed with Carry-Forward indirect cost rate. This rate is subject to adjustments to reflect actual over or under recoveries in prior years resulting in a carry forward adjustment.

These are just a few examples of why we believe the Bureau has been unsuccessful in accurately projecting contract support costs, but has made tremendous improvements over the years. Later in my testimony I will address the second part of your question asking us to describe what steps we are taking to assure funding shortfalls do not continue to occur.

Tribal Contracting and Bureau's Staffing Trends: It is axiomatic that when a tribe takes over a Bureau program all funds that would otherwise be available to the Bureau to operate that program (based on a negotiated share of the total) are transferred to the tribe's priority allocation account. A reduction of Bureau personnel must occur because the funds to pay for Bureau staff is no longer available. Therefore, I am confident that the Bureau has been successful not only in carrying out the intent of Congress to turn over federal control of programs and services to Indian tribes but also

in reducing the federal bureaucracy as tribes do take over. In response to your question regarding barriers there are no barriers to downsizing the Bureau in response to increased contracting and or compacting. At this point I'd like to review the recent trends in contracting and compacting, Bureau staffing trends, and contract support cost funding history.

In response to your questions regarding downsizing and parallel reductions in federal staffing let me answer by showing first a chart depicting increases in tribal contracting and the Bureau's staffing trends for the total Bureau staff, from 1981 through the year 2000. (**Exhibit A- BIA Staffing Trends 1981-2000**) This chart clearly shows a significant reduction of the Bureau workforce. As a later chart will show a large portion of the Bureau's staff reductions can be directly attributed to tribal contracting and compacting. On the basis of these figures we are comfortable in projecting that over the next five years, assuming there is no congressional moratorium on new and expanded contracts, compacts, and grants approximately 70 non-education programs are likely to be contracted and/or compacted by tribes. (**Exhibit B - Projected Reductions in BIA FTE's 2000-2005**). Accordingly, we also project that an estimated 366 non-education FTE would be affected further reducing Bureau staffing levels. This would result in reducing the Bureau's staffing to or near a level minimally needed to carry out only residual functions and activities.

An additional factor to further reduce FTEs will depend on the Navajo Nation's plan to take control of all 66 BIA schools located on the Navajo reservation. Currently, 27 of the schools are operated as grant schools with the remaining 39 as BIA operated schools.

Bureau's Self-Determination, Self-Governance & Funding Trends: I have included the following exhibits that depict:

- Exhibit C--BIA Funding Trends.
- Exhibit D--Contract Support Funding History

Exhibit C - "BIA Funding Trends", shows that the levels of self-determination and self-governance compacting is rising but has stabilized to a certain degree.

And, while contracting and compacting has remained constant, a tribal decision to contract or compact is most often influenced by the level of direct contract support funding available for a program or activity.

Exhibit D - "Contract Support Funding History", (please note that the green arrows depict projections.)

In Fiscal Year 1995, the Bureau received for the first time appropriations for new and expanded contracts, i.e. the Indian Self-Determination Fund (ISDF). Except for the first two years, the annual appropriation for the ISDF has been \$5 million. As we develop a new method(s) to address the funding of contract support costs, this amount will become a critical source of funds for new and expanded contract/compacted programs.

Contract Support Costs:

At this time I would like to talk about Contract Support and what we expect will be our solution to a longstanding funding problem. First let me give you a brief background of this problem.

Background:

The Bureau began paying for indirect costs of Indian tribes and tribal organizations in 1976 as they began contracting for Bureau programs under Public Law 93-638. These costs were paid out special appropriations entitled Contract Support Funds. It is fair to say that from the outset, funding for contract support has generally not been sufficient to pay all of the costs of contracting. And, as I previously stated there are several reasons for this situation. This Committee is acutely aware of the negative impacts funding shortfalls has had on tribal contractors. By the same token the benefits of tribal contracting and or compacting cannot be over emphasized. In addition to greater flexibility in program design and requirements, tribes can tailor programs or services to meet the local or unique needs of their tribal communities. Thus, it becomes imperative that we work together to solve the contract support problem in the most expedient and efficient manner. To that end I have taken several steps to begin developing a solution to this problem. They are described herein:

Recommendations:

Establishment of Contract Support Work Group: We have initiated discussions with the Indian Health Services (IHS) to work together to develop a new contract support policy that will provide guidance and direction to field offices on the types of costs allowed for tribal overhead under Public Law 93-638 contracts. Most importantly, it will provide guidance on Section 106 (25 U.S.C. 450j-1) obligations. In conjunction with the National Congress of American Indians' (NCAI) workgroup on CSF, the Bureau and IHS are also analyzing a variety of other options. A report will be provided to the Committee in April, 1999. In addition, a GAO report on CSC will be provided to the Congress in June 1999. (See S.Rept. 105-227, pp. 51&52)

Bureau Position: As a preface to our commitment to find a solution to the contract support funding problem we have taken the position that:

- the Bureau will work with other federal agencies involved in contracting to try and obtain funding so that DOL, HHS, HUD, ED, USDA, and DOJ may pay their fair share.
- we will continue to disburse CSC funds based on a pro-rata basis.
- we will evaluate tribal requests for payment of certain direct costs.
- we will work with Congress and tribes to develop contract solutions that are more in line with the budget cycle, in order to better predict future CSC needs.

Some of the Bureau options currently under review are:

- re-examining the use of tribal indirect cost rates, as negotiated by the Office of the Inspector General in determining annual CSC needs in favor of negotiated lump sum amounts

- reviewing with other federal agencies the continuation of "caps" on the amount of CSC paid to tribes
- funding 100% of CSC needs within existing resources
- provide for justified CSC increases to the TPA base accounts
- provide for more timely and accurate reporting of CSC to Congress
- look at options that will improve the efficiency of tribal operation of programs and of distributing contract support costs.

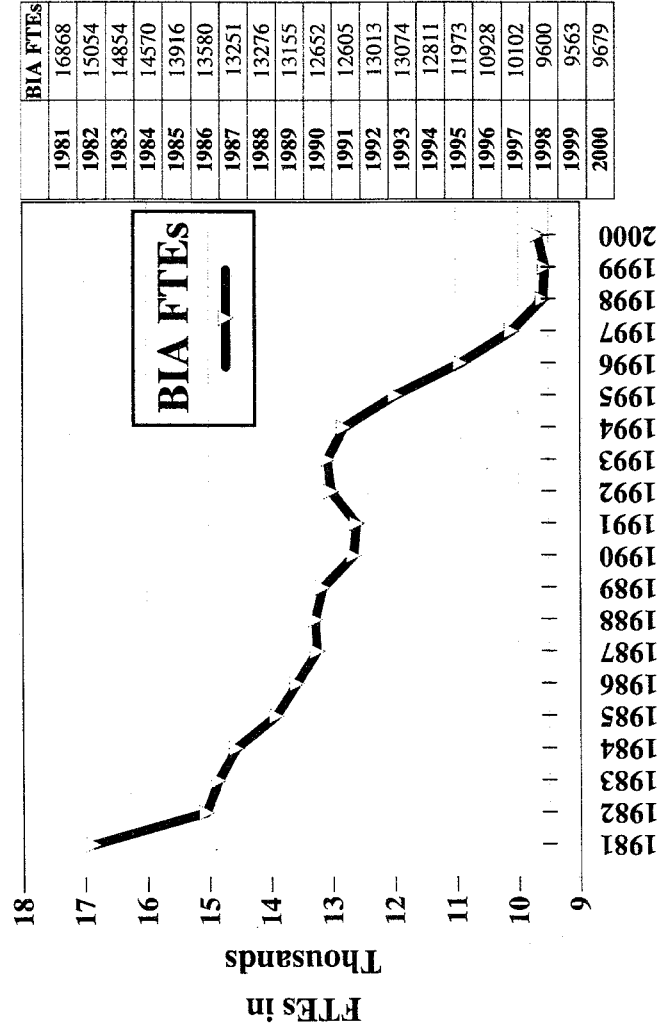
Conclusion:

In summary, I believe the Bureau's current method of distributing contract support has improved tremendously and funding levels have been increasing steadily, even after Congressional cuts in the mid-1990s. The Bureau is aware more can be done to further improve contract support funding. The Bureau, in full cooperation with IHS, NCAI, and tribal leaders, will succeed in its effort to continue to pursue solutions to the contract support funding issue, and that the solution will provide for equitable and fair distribution of CSC. We hope that this Committee will work with us to develop an improved method to distribute contract support costs.

This concludes my statement and I will be happy to answer any questions you may have. Thank you.

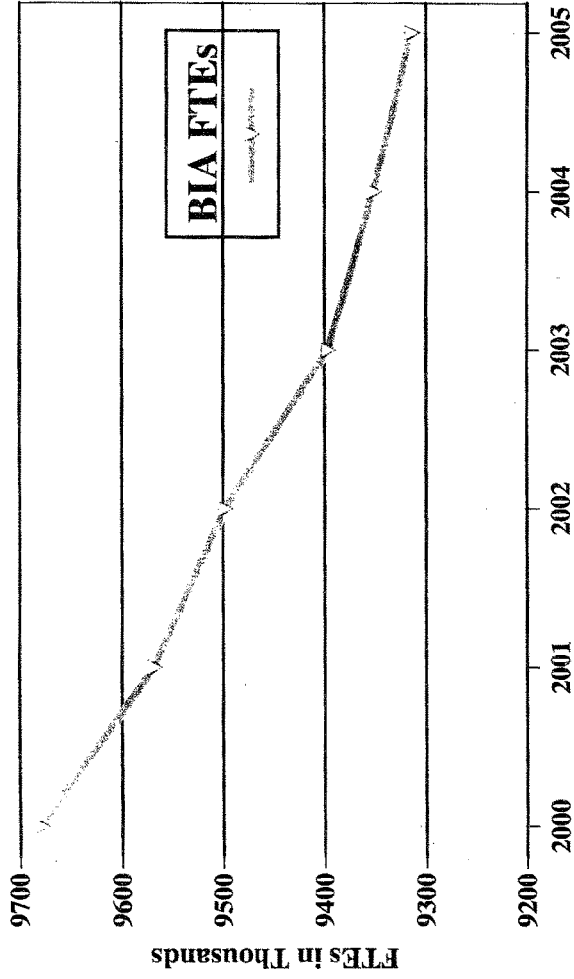
BIA Staffing Trends: 1981 - 2000

By Year and Full-Time Equivalents



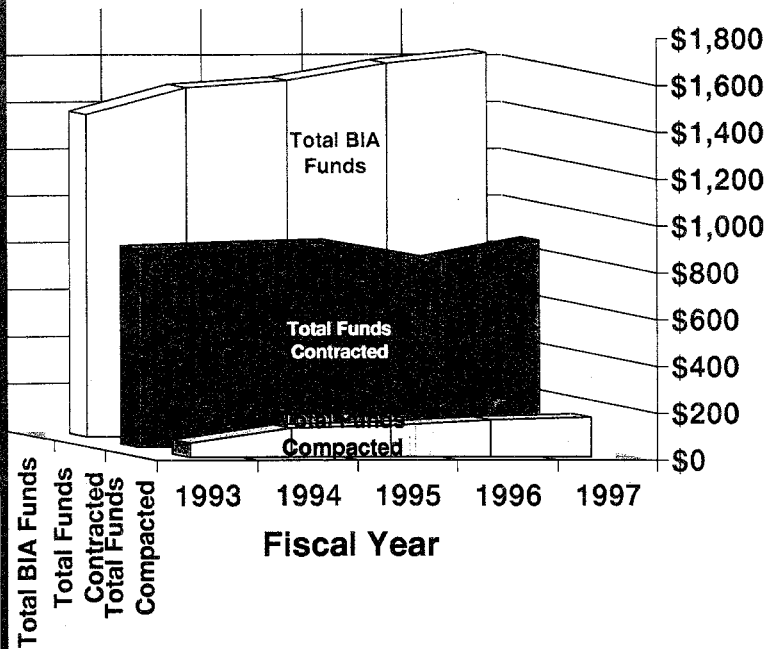
Projected Reductions in BIA FTEs: 2000 - 2005

B



BIA Funding Trends 1993 - 1997

C



	1993	1994	1995	1996	1997
Total Funds Compacted	60.7	123.5	133.2	157.2	169.2
Total Funds Contracted	843.3	859.5	869.8	797.1	879.6
Total BIA Funds	1375.1	1490.8	1520.4	1592	1638.8

Source: BIA, 1998. Note: The "Total Funds Contracted" excludes the totals from "Total Funds Compacted."

Contract Support Funding 1995 - 2000 - D

	CSC Need	Enacted	% Funded	Shortfall	% Shortfall
1995	103,945	95,640	92%	8,305	8%
1996	104,526	90,829	87%	13,697	13%
1997	117,346	90,829	77%	26,517	23%
1998	131,714	105,829	80%	25,885	20%
1999	138,913	114,891	83%	24,022	17%
2000	144,624	121,338	84%	23,286	16%

COUNCIL ANNETTE ISLANDS RESERVE

METLAKATLA INDIAN COMMUNITY

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March 3, 1999

Honorable Don Young, Chairman
House Resources Committee
1324 Longworth Building
Washington, D.C. 20515

Attn: Debbie Callis

Re: House Resource Committee Hearing
Contract Support Funding

Dear Chairman Young:

On behalf of the Metlakatla Indian Community, Annette Islands Reserve, we respectfully request that this letter be made part of the official hearing record for your committee's February 24th hearing on tribal contract support costs.

Pursuant to the Committee's request, we enclose five (5) copies. We outline below some possible reform measures designed to improve the reliability and effectiveness of the current contract support system for the purpose of strengthening and achieving the goals of the federal policy of tribal self-determination and self-governance. The Metlakatla Indian Community is a federally recognized tribal governing body which exercises jurisdiction over the Annette Islands Reserve under a Constitution and By-Laws approved by the Secretary of the Interior. The Community is the beneficial owner of the Reserve and operates federal programs for its members under tribal self-government agreements with the Secretary of the Interior and the Secretary of Health and Human Services.

The suggestions presented and discussed below require significant further study, but the Community feels that they should be presented and considered as they may offer an opportunity for developing a permanent solution to the contract support 'problem' which would be acceptable both to the tribes and to Congress.

We also note that these ideas are presented in the context of a major challenge by some in Congress to the core principles underlying tribal sovereignty and the policy of Indian Self-determination. It is our firm belief that tribes must strenuously fight any effort to erode tribal sovereignty and the policy of self-determination. In our view, the most effective method to fight such challenges is to present a plan that answers the questions and concerns that have been raised about 'contract support' funding, but which makes no compromises on issues of tribal sovereignty and only minimal changes to the Indian Self-Determination Act, while preserving the overall policy of self-determination. We believe that the ideas outlined below are consistent with these goals.

We urge that your Committee keep in focus the key role which 'contract support' funding has played in permitting tribes to exercise their rights under P.L. 93-638 without paying a financial penalty for

contracting (i.e., without having to reduce the level of services to pay tribal overhead costs which do not burden federally operated programs). While we have never received the full amount to which we are entitled under section 106 (a) (2) of the Act, we have received sufficient funding for contract support to enable us to proceed with self-determination and self-governance on a financially viable basis. We think that the reforms proposed below, when combined with full funding for contract support, would assure that Indian tribes could continue along the road to effective tribal self-government.

Tentative Contract Support Reform Proposal

- 1] On October 2, 1999, the moratorium on new or extended contracts and compacts would be lifted, but the '638' process would be modified so as to allow improved budget forecasting by the agencies and Congress of contract support need.
- 2] Although tribes would be permitted to contract or compact a program after the current 90-day notice period, tribes would be required to submit their requests for contract support costs (CSC) at least two years before the beginning of the fiscal year in which the tribes would begin receiving CSC funds (thus, before October 1). However, for FY 2000, requests would be accepted through December 31, 1999, for CSC payments to be made in FY2002.
- 3] The Inspector General (IG) of the Department of the Interior (or in some cases, the DHHS office of Cost Allocation) would be charged with conducting an initial negotiation with the tribe to determine the reasonableness of the tribe's CSC request (possibly including direct and start-up, in addition to indirect costs). This initial negotiation (to be conducted shortly after the request is submitted by the tribe) will help to ensure that the HIS and BIA are able to prepare accurate and reasonable budget requests for CSC funds.

The IG and the tribe would revisit the request during the year in which CSC funds are to be distributed to the tribe so as to ensure that the previously negotiated level of funds continues to accurately reflect the tribe's CSC requirement. These negotiations will be guided by a new OMB circular (see #8 below), which will specifically address the standards for determining necessary contract support for contracts and compacts entered into under the Indian Self-Determination Act.

We understand that the IG has expressed a reluctance to become involved in determining the reasonableness of requests for direct and start-up contract support funds, in addition to his current responsibility to negotiate indirect cost agreements. Clearly, this issue needs further consideration by tribes and the federal agencies. We note, however, that there are a number of methods to address this problem. For example, the new OMB circular to be developed could provide that all eligible contract support be defined by the Act be included in the Tribe's indirect cost pool (since the rules of OMB Circular A-87 would no longer govern the negotiations, its limited definition of 'indirect costs' would not be applicable). For tribes with programs in addition to BIA and IHS programs, two rates could be used. Another option would be to have the IG review the reasonableness of the direct and start-up costs, as well as indirect costs.

- 4] Tribes would not be prohibited from beginning contracting before receiving their CSC funds. However, section 106 of the Indian Self-Determination Act would be amended and contracts would make clear that tribes have no legal entitlement to CSC during the two-year waiting period. (Two years is quite short compared to the wait of at least four to five years under the existing ISD Queue).

Some tribes have raised concerns about making any amendment to the funding requirements contained in section 106 of the Act. We recognize the risks involved in proposing amendments to section 106. However, it is our understanding that key members of Congress are considering 'solutions' to the contract support funding problem that would greatly undermine the federal Indian Self-Determination policy by restricting the rights of tribes to begin contracting in the future.

In contrast, our approach would not prevent tribes from contracting and thus would not disturb tribal sovereignty or the overall policy of self-determination. It would, however, address Congress' concern that it knows in advance how much contract support to appropriate to avoid legal liability.

We further offer this approach with the understanding that any amendment to P.L. 93-638 would be considered and acted upon by the appropriate authorizing committees of the Congress and that the appropriations committees would refrain from amending the Act through the appropriations process.

- 5] In FY 2000 and FY 2001 (during the transition period) all CSC increases would be used to address the current shortfall in contract support funding. The following options have been discussed and should be given further consideration:
 - Option 1: Tribes would be divided into quartiles based on their overall level of CSC funding. CSC increases would be distributed so that each quartile would receive a portion of the funds. However, quartiles with the greatest levels of need would receive proportionally larger shares of the increases, with the goal of achieving parity of funding at as close to 100 percent as possible.
 - Option 2: CSC increases would be distributed with priority given to those tribes with the greatest percentage of unfunded CSC need. Thus, tribes with relatively high levels of overall CSC funding would not receive any funds until tribes with lower funding levels were brought up to parity with the higher funded tribes.
 - Option 3: First priority would be given to remaining Queue requests, to which CSC increases would be applied on a straight pro-rata basis. Funds appropriated in excess of the Queue amount would be applied to the ongoing shortfall, also on a straight pro-rata basis.
- 6] CSC funding for indirect costs for existing contractors would not be reduced, unless dictated by lower indirect cost rates.
- 7] The IHS and BIA would be required to report to Congress with their FY 2002 budget requests CSC funding requirements sufficient to cover all requests (at the level negotiated with the IG) made before December 31, 1999.

For FY 2003, the agencies would be required by statute to report to Congress the amount of funds needed to cover all CSC requests made on or before September 30, 2000, and for any remaining CSC shortfalls from the previous years. This same process would be used in all subsequent years.
- 8] OMB will be asked to develop a circular to provide for the manner in which CSC requests would be negotiated and standards to be applied, as well as to help ensure that the

Administration includes in its budget requests sufficient funds to satisfy the CSC need reported to Congress.

- 9] Beginning in FY 2002, all CSC increases would be used to pay 100 percent of need for the requests submitted two years before. Requests would be paid on a first come, first served basis, with any excess amounts used to address the shortfall, and if none, carried over to the next year.
- 10] In the case of CSC requests submitted in FY 1999 and before, but for which no contract has been signed (due, for example, to the current moratorium), the date of the original CSC request will be used for determining priority in receiving CSC funds in FY 2002. An initial negotiation should be conducted with the IG or an DHHS OCA as soon as possible after October 1, 1999 (when the new system is in place), to determine the reasonableness of these requests, especially since some were first submitted more than a year ago.
- 11] A consistent concern raised by some congressional staff is the loss of economies of scale that results when small tribes contract their own programs. It has been suggested that growth in contract support costs could be reduced by preventing small tribes from contracting their own programs – essentially stripping them of their sovereign rights under the Indian Self-Determination Act. This approach has already been applied by Congress to tribes in Alaska, where a three year moratorium has been imposed to prevent Alaskan Native Villages (which are recognized as tribes by the Secretary and in section 4 of P.L. 93-638, from withdrawing from tribal consortia to contract their own programs.

We believe that any effort to limit the rights of tribes (whatever their size) should be reviewed, considered and acted upon by your Committee, not the Appropriations Committee. An alternative method can be developed that would help to address the cost issue, but which in no way intrudes on tribal sovereignty. For example, it might be possible to establish a voluntary program where tribes of all sizes would be rewarded for cooperating with other tribes to combine programs and pool overhead costs. The CSC savings from such efforts could be approximated and the tribes could be guaranteed a portion of such savings (perhaps 50 percent) in additional program funds. Tribes, which are already in consortia, should also be rewarded. This idea could be tested as a pilot project in Alaska in exchange for lifting the current moratorium.

We very much appreciate your holding a hearing on this important matter and for your consideration of our comments. It is our hope that these ideas will aid the effort to develop a lasting solution to the so-called 'contract support' problem which will permit full realization of the goals of P.L. 93-638 by all tribes.

Sincerely,

Metlakatla Indian Community


Tim Gilmartin, Mayor

cc: Cynthia Ahwinona

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February 26, 1999

BY TELECOPIER
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MARVIN J. SONOSKY (1909-1997)

The Honorable Don Young
Chairman, House Resources Committee
United States House of Representatives
1324 Longworth House Office Building
Washington, D.C. 20515

Re: February 24, 1999 House Resources Committee oversight hearing on contract support costs

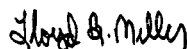
Dear Congressman Young:

Earlier this week I wrote to clarify the Resources Committee's hearing record regarding the FY 2000 contract support cost shortfall for the Indian Health Service and the Bureau of Indian Affairs.

Today the Indian Health Service met with the National Congress of American Indians and reported that, as a result of program increases contained in the President's budget, the projected shortfall for FY 2000 was very recently increased by \$12,630,000 to \$106,037,000 (with total contract support requirement projected at \$309,818,440). We wanted to be sure to let you know of these adjustments immediately.

The National Congress of American Indians and the many tribes we represent thank you once again for your continuing strong commitment to tribal self-determination.

Sincerely,


Lloyd B. Miller

LBM:bnm

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The Honorable Don Young
Chairman, House Resources Committee
United States House of Representatives
1324 Longworth House Office Building
Washington, D.C. 20515

Re: February 24 Oversight Hearing on Contract Support Costs

Dear Congressman Young:

YKHC Vice-President Orie Williams asked that I write to clear up some of the confusion from yesterday's hearing regarding precise contract supports cost funding levels for FY2000.

On the IHS side, I enclose a two-page document that summarizes an elaborate set of the latest working tables produced by the Indian Health Service. Although much of the document summarizes what IHS is doing in FY1999, the key to the document is found in Part VI, entitled "CSC Need Projection for FY2000." The report projects total contract support cost needs in FY2000 (including inflation and \$15 million for anticipated new self-determination activities) to be \$297,188,440. Against this amount, IHS's FY1999 appropriation is \$203,781,000. The increased amount therefore needed in FY2000 to bring all self-determination contracting and compacting organizations whole is the difference, or \$93,407,440.

On the BIA side, total tribal needs in FY1999 are estimated at \$139 million, when tribal needs for "direct" contract support costs are excluded. Assistant Secretary Gover testified that in FY2000 the BIA may well begin paying "direct" contract support costs. If direct contract support costs are added in, the estimated total contract support costs need rises to \$167 million. At the FY1999 funding level of \$115 million, this leaves an estimated shortfall of \$52 million in FY2000.

The Honorable Don Young
February 25, 1999
Page 2

As the tribal testimony yesterday reflected, Indian health care providers are operating in crisis mode. The current contract support shortfalls only make the crisis worse. YKHC, the National Congress of American Indians and other tribal providers throughout the country respectfully ask that you do everything in your power to secure these increases in contract support costs from the Budget Committee and the Appropriations Committee.

Thank you so much for your continuing commitment to the country's Self-Determination Policy.

Sincerely,



Lloyd Benton Miller

LBM:dd

cc: Cynthia Ahwinona

**SUMMARY SHEET****I. Number of Tribes...**

Total number of Tribes Contracting	330
Total number of Individual ISD Requests	187
Total number of Tribes On the ISD Queue	135
Number of ISD Requests to be finalized	55
Total number of Tribes On the ISD Queue AT 70% or Higher	48
Total number of Tribes On the ISD Queue at LESS THAN 70%	87
After \$35 mil distribution, # of Tribes on the ISD Queue LESS THAN 70%	18
Total number of Ongoing Tribes AT 70% or Higher	187
Total number of Ongoing Tribes at LESS THAN 70%	27

II. Additional \$\$ distributed and remaining need to fund XX% LNF

Total \$\$ distributed to bring Queue Tribes to 70%	14,674,371		
Total \$\$ needed to bring remaining 18 Queue Tribes to 70%	981,246	35,455,416	
Total \$\$ needed to bring remaining 27 Ongoing Tribes to 70%	818,412		
Total new \$\$ distributed in FY 99 to raise CSC LNF to 70%	36,265,828		
	<u>Total</u>	<u>Ongoing Tribes</u>	<u>Queue Tribes</u>
Total \$\$ needed to bring ALL Tribes up to at least 80% LNF in FY '99	13,129,846	2,044,635	11,045,212
Total \$\$ needed to bring ALL Tribes up to at least 90% LNF in FY '99	30,423,949	5,389,467	25,034,481
Total \$\$ needed to bring ALL Tribes up to at least 100% LNF in FY '99	52,286,598	11,582,908	40,703,690

III. CSC Breakdown by %

	<u>Total ISD Queue</u>		<u>Total FY 1999 Requirements</u>	
CSC Requirement for Startup / % of Total CSC	10,004,545	16.69%	10,004,545	3.83%
CSC Requirement for DCSC / % of Total CSC	18,796,944	31.35%	57,602,929	22.05%
CSC Requirement for IDC / % of Total CSC	<u>31,149,475</u>	<u>51.96%</u>	<u>123,600,246</u>	<u>74.12%</u>
	59,950,964	100.00%	261,208,420	100.00%

IV. CSC Percentages (%)

Total Program Funds under PL 93-638 Awards	844,422,201	
Total CSC Awarded	203,781,000	
Total CSC Requirements	<u>261,208,420</u>	
CSC as a % of Program Funds	24.1%	30.9%
CSC as a % of Total Requirements		23.6%
% of CSC Requirements for Ongoing Programs funded by Areas (FY 98)		87.79%
% of Overall CSC Requirements funded by Areas (FY 98)		66.47%
% of Overall CSC Requirements available (FY 99)		80.35% Avg.
Base CSC % Proposed TO BE FUNDED		70.00%

<u>V. Total CSC LNF by Area:</u>	<u>FY 1998</u> <u>Based on Tribal</u> <u>Ongoing Programs</u>	<u>FY 1998</u> <u>Based on Total</u> <u>Tribal Programs</u>	<u>Total CSC LNF</u> <u>after \$25 mil.</u> <u>Distribution</u>
Aberdeen	64.2%	60.8%	71.43%
Alaska	87.6%	58.1%	78.55%
Albuquerque	91.5%	77.0%	81.17%
Bemidji	80.6%	73.5%	80.72%
Billings	85.2%	58.9%	81.39%
California	82.7%	67.5%	77.52%
Nashville	92.5%	90.4%	93.36%
Navajo	88.6%	85.7%	85.99%
Oklahoma	86.2%	66.1%	80.92%
Phoenix	86.2%	52.4%	78.46%
Portland	93.7%	81.4%	84.58%
Tucson	22.0%	81.8%	81.82%
---TOTALS	86.3%	66.3%	80.35%

VI. CSC Need Projection for FY 2000

Total CSC Funding Available in FY 1999	\$2,100,000
FY 1998/1999 CSC Shortfall	\$2,285,000
Inflation for FY 1999 and 2000 @ 5% per yr. (\$261.2 mil. * 5% * 2 yrs.)	26,120,000
New & Expanded ISD Need for FY 2000	15,880,000
TOTAL FY 2000 CSC Requirement	\$27,185,000
- LESS FY 1999 CSC Appropriation	(\$25,211,000)
FY 2000 Projected CSC Shortfall	\$2,974,000